DOCUMENT RESUME

ED 469 421 PS 030 709

TITLE	Rhode Island KIDS COUNT Factbook, 2002.
INSTITUTION	Rhode Island KIDS COUNT, Providence.
SPONS AGENCY	Annie E. Casey Foundation, Baltimore, MD.; Rhode Island Foundation, Providence.; Robert Wood Johnson Foundation, Princeton, NJ.; David and Lucile Packard Foundation, Los Altos, CA.; Ford Foundation, New York, NY.; Ewing Marion Kauffman Foundation, Kansas City, MO.
PUB DATE	2002-00-00
NOTE	261p.; For 2001 Factbook, see ED 454 951. Additional support provided by Prince Charitable Trusts, CVS/Pharmacy, Ocean State Charities Trust, and Hasbro Charitable Trust.
AVAILABLE FROM	Rhode Island KIDS COUNT, One Union Station, Providence, RI 02903. Tel: 401-351-9400; Fax: 401-351-1758; e-mail: rikids@rikidscount.org. For full text: http://www.rikidscount.org.
PUB TYPE	Numerical/Quantitative Data (110) -- Reports - Descriptive (141)
EDRS PRICE	EDRS Price MF01/PC11 Plus Postage.
DESCRIPTORS	*Adolescents; Birth Weight; Child Abuse; Child Care; *Child Health; Child Neglect; Child Support; Child Welfare; *Children; Demography; Early Parenthood; Elementary Secondary Education; Family Income; Health Insurance; High School Graduates; Incidence; Infant Mortality; Lead Poisoning; Low Income Groups; Mortality Rate; Out of School Youth; Poverty; Prenatal Care; Preschool Education; Reading Achievement; *Social Indicators; Special Education; State Surveys; Statistical Surveys; Substance Abuse; Tables (Data); Trend Analysis; *Well Being; Youth Problems
IDENTIFIERS	*Indicators; Project Head Start; *Rhode Island; Subsidized Child Care Services

ABSTRACT

This KIDS COUNT databook is the seventh annual profile examining statewide trends in the well-being of Rhode Island's children. The statistical portrait is based on 49 indicators (6 new indicators in this databook) in 5 areas: (1) family and community (including child population, children in single parent families, and racial and ethnic diversity); (2) economic well-being (including child support, child poverty, children in families receiving food stamps, children in the Family Independence Program, and children receiving school breakfast); (3) health (including children's health insurance, children with special needs, breastfeeding incidence, dental care access, children's mental health, infant mortality, and births to teens); (4) safety (including child and teen deaths, homeless children and youth, children of incarcerated parents, juveniles referred to family court, and out-of-home placement); and (5) education (including infant/preschool child care, Head Start enrollment, school-age child care, child care subsidies, special education enrollment, student mobility, fourth-grade reading skills, high performing schools, school attendance, and high school graduation). Following an overview focusing on family economic security and educational attainment, the databook defines each indicator, describes its significance and trends, describes efforts to address problems or meet needs,

Reproductions supplied by EDRS are the best that can be made
from the original document.

and for most indicators presents relevant data for the state, 39 cities and towns, and an aggregate of the 5 cities with the highest child poverty rates. The databook concludes by describing the methodology, listing KIDS COUNT committee members, and acknowledging contributors. (KB)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 469 421

Rhode Island Kids Count Factbook, 2002.

Rhode Island KIDS COUNT
Providence, RI

2002

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

X This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

Elizabeth Burke Bryant

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

1

PS 030209

2

BEST COPY AVAILABLE

Table of Contents

OVERVIEW 3

FAMILY AND COMMUNITY

Child Population 6-7
Children in Single Parent Families 8-9
*Racial and Ethnic Diversity 10-11
Racial and Ethnic Disparities 12-13

ECONOMIC WELL-BEING

Median Household Income 16-17
Cost of Rent 18-19
Secure Parental Employment 20-21
Children Receiving Child Support 22-23
Children in Poverty 24-27
Children in the Family Independence Program 28-31
Children Receiving Food Stamps 32-33
Children Participating in School Breakfast 34-35

HEALTH

Children's Health Insurance 38-39
Access to Dental Care 40-41
Children's Mental Health 42-43
*Children with Special Needs 44-45
Women and Children Receiving WIC 46-47
*Breastfeeding 48-49
Women with Delayed Prenatal Care 50-51
Low Birthweight Infants 52-53
Infant Mortality 54-55
Children with Lead Poisoning 56-57
Children with Asthma 58-59
Births to Teens 60-61
Alcohol, Drug, and Cigarette Use by Teens 62-63
Additional Children's Health Issues 64-65

SAFETY

Child Deaths 68-69
Teen Deaths 70-71
Homeless Children 72
Homeless Youth 73
Juveniles Referred to Family Court 74-75
Juveniles at the Training School 76-77
*Children of Incarcerated Parents 78-79
Children Witnessing Domestic Violence 80-81
Child Abuse and Neglect 82-85
Children in Out-of-Home Placement 86-89

EDUCATION

Infant and Pre-School Child Care 92-93
Children Enrolled in Head Start 94-95
School-Age Child Care 96-97
Children Receiving Child Care Subsidies 98-99
Full-Day Kindergarten 100-101
English Language Learners 102-103
Children Enrolled in Special Education 104-105
*Student Mobility 106-107
Fourth-Grade Reading Skills 108-109
*High Performing Schools 110-111
School Attendance 112-113
Suspensions 114-115
High School Graduation Rate 116-117
Teens Not in School and Not Working 118-119

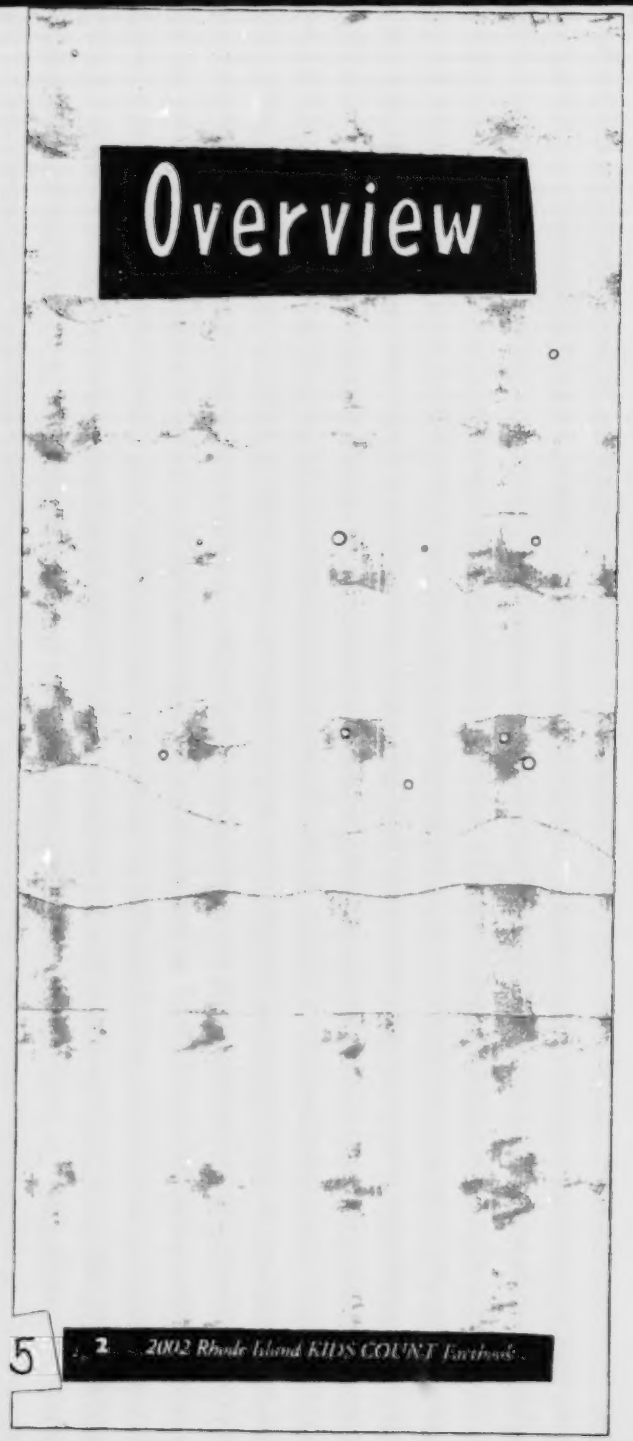
METHODOLOGY 122-124

COMMITTEES 125-127

ACKNOWLEDGEMENTS 128-130

**New Indicator*

Overview



Ode to My Shoes

By Francisco X. Alarcón

mis zapatos
descansan
toda la noche
bajo mi cama

cansados
se estiran
se aflojan
las cintas

muy anchos
se duermen
y sueñan
can andar

recorren
los lugares
adonde fueron
en el día

y amanecen
contentos
relajados
suavecitos

my shoes
rest
all night
under my bed

tired
they stretch
and loosen
their laces

wide open
they fall asleep
and dream
of walking

they revisit
the places
they went to
during the day

and wake up
cheerful
relaxed
so soft

The *2002 Rhode Island KIDS COUNT Factbook* is the eighth annual profile of the well-being of children in Rhode Island. The annual Factbook is an important tool for planning and action by community leaders, policy makers, advocates, and others working toward changes that will improve the quality of life for all children.

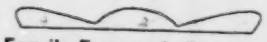
The annual Factbook tracks progress across five areas of child well-being. All areas of child well-being are interrelated and critical throughout a child's development. A child's safety in his family and community affects his school performance; a child's economic security affects her health and education. The *2002 Rhode Island KIDS COUNT Factbook* reflects these interrelationships and builds a framework to guide policy, programs for children, and individual service on behalf of children.

The *2002 Rhode Island KIDS COUNT Factbook* provides a statistical portrait of the status of Rhode Island's children. Information is presented for the state of Rhode Island, each city and town, and an aggregate of the five cities in which more than 15% of the children live in poverty. These cities — referred to as the "core cities" in the Factbook — are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The Factbook provides community-level information on each indicator in order to emphasize the significance of the surrounding physical, social, and economic environment in shaping outcomes for children. Communities and neighborhoods do matter - the actions of community leaders, parents, individuals, businesses, government leaders, and elected officials greatly influence children's chances for success and the challenges they will face.

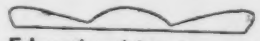
By examining the best available data statewide and in Rhode Island's 39 cities and towns, Rhode Island KIDS COUNT provides an information base that can result in more effective policy and community action on behalf of children. Tracking changes in selected indicators can help communities to set priorities, identify strategies to reverse negative trends, and monitor progress.

The *2002 Rhode Island KIDS COUNT Factbook* examines forty-nine indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. Six new indicators are included in this edition of the Factbook. The most current and reliable data available are presented for each indicator.



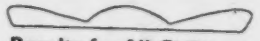
Family Economic Security

Children most at risk of not achieving their full potential are children in poverty. Despite overall economic growth in the past decade, many Rhode Island families have experienced income losses since the late 1980s. The child poverty rate has increased from 14% in 1990 to 18% in 1999. More than half of Rhode Island's 38,611 poor children live in extreme poverty - with a family income less than $8,825 (half of the federal poverty level of $17,650 for a family of four). Even those with incomes above the official poverty level have a difficult time meeting the high costs of housing, utilities, child care, and health care. Child care subsidies, health care subsidies, affordable housing, and tax policies that support working families are critical tools to ensure the economic well-being of Rhode Island families.



Educational Attainment

Improving student achievement and high school graduation rates in Rhode Island requires that all sectors work together to provide opportunities for infants, young children, and teens in the state's high poverty neighborhoods. Children who participate in high-quality preschool programs and read on grade level by fourth grade are more likely to complete high school. Student achievement can be improved when schools have high expectations for all students, effective curricula and teaching methods, adequate accountability methods, and prepared and sufficiently supported teachers. Young people who complete high school prepared to go on to higher education or to enter the workforce are more likely to be capable, self-sufficient adults who contribute to the community.



Results for All Children

Significant racial and ethnic disparities in child outcomes continue to exist in Rhode Island. Black, Hispanic, Asian and Native American children are three times more likely than White, non-Hispanic children to be poor and more likely to live in Rhode Island's poorest urban neighborhoods. Strategic efforts that engage diverse leadership can ensure that all Rhode Island children have the resources they need to thrive, including economic security, effective schools, quality child care, quality health care, affordable housing, and caring communities.

Family and Community

9

I, Too

by Langston Hughes

I too, sing America.

I am the darker brother.
They send me to eat in the kitchen
When company comes,
But I laugh,
And eat well,
And grow strong.

Tomorrow,
I'll be at the table
When company comes.
Nobody'll dare
Say to me,
'Eat in the kitchen,'
Then.

Besides,
They'll see how beautiful I am
And be ashamed—

I, too, am America.

BEST COPY AVAILABLE

11

12

Child Population

DEFINITION

Child population is the total number of children under the age of 18 and the percentage change between 1990 and 2000.

SIGNIFICANCE

According to the decennial census of April 2000, there were 1,048,319 Rhode Island residents. Of these, 24% or 247,822 were children under age 18. This is a 10% increase since 1990. There were 22,132 more children in 2000 than in 1990.[1]

The number of U.S. children recorded by the Census 2000 was the largest in history at 72.3 million.[2] This represents a substantial increase in the child population over the decade of the 1990's. Children now make up 26% of the U.S. population.[3] Nearly all states saw increases in child population with only five states and the District of Columbia experiencing declines.[4]

The change in the population under age 18 varied widely among towns in Rhode Island. The largest increase was in West Greenwich where the child population increased by 58%.[5] Although the child population increased in most Rhode Island towns, some locations had decreases. Both Burrillville and Newport had reductions of 10% in the number of residents under age 18.[6]

In 2000, the number of family households with children under age 18 in Rhode Island was 124,867. This represents 31% of all Rhode Island households.[7]

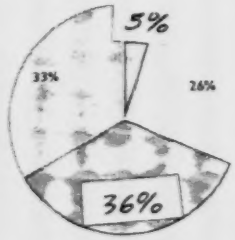
In 2000, there were slightly more boys than girls in the state. There were 120,623 girls under age 18 in Rhode Island, compared to 127,199 boys.[8] Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. Nationally, and in Rhode Island, the increase in the child population was led by minority children.[9] In Rhode Island, the number of White, non-Hispanic children declined over the decade of the 1990's by nearly 9,000 children, while the number of minority children increased by 31,000 to nearly 68,000.[10]

Currently there are more adolescents and fewer young children in Rhode Island than there were at the beginning of the 1990's. In 1990, 36% of Rhode Island's children were ages 5 and under.[11] In 2000, the youngest children made up 31% of all children in the state.[12] During the ten year period, the percentage of children ages 6 to 11 went from 33% to 36% and the percentage of youth ages 12 to 17 increased from 31% to 33%.[13,14]

Rhode Island's Children, 2000

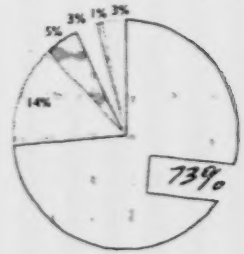
By Age

5%	Under age 1
26%	Ages 1 to 5
36%	Ages 6 to 11
33%	Ages 12 to 17



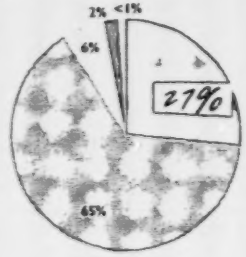
By Race/Ethnicity

73%	White
14%	Hispanic
5%	African American
3%	Asian and Pacific Islander
1%	Some Other Race
3%	Two or More Races



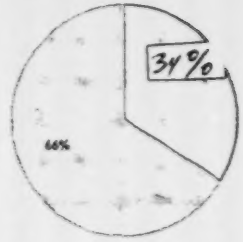
By Family Structure

27%	Single Parent Families
65%	Married Couple Families
6%	Other Relatives
2%	Unrelated Individuals
<1%	Group Quarters



By Residence

34%	Core Cities*
66%	Remainder of State



n = 247,822

** Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.*

Source: U.S. Census Bureau, Census 2000, Summary File 1.

BEST COPY AVAILABLE

Table 1.

Child Population, Rhode Island, 1990 and 2000

CITY/TOWN	1990 TOTAL POPULATION UNDER AGE 18	2000 TOTAL POPULATION UNDER AGE 18	CHANGE IN POPULATION UNDER AGE 18	% CHANGE IN POPULATION UNDER AGE 18
Barrington	3,912	4,745	833	21%
Bristol	4,380	4,399	19	0%
Burrillville	4,479	4,043	-436	-10%
Central Falls	4,810	5,531	721	15%
Charlestown	1,575	1,712	137	9%
Coventry	7,626	8,389	763	10%
Cranston	14,673	17,098	2,425	17%
Cumberland	6,427	7,690	1,263	20%
East Greenwich	2,913	3,564	651	22%
East Providence	10,657	10,546	-111	-1%
Exeter	1,521	1,589	68	5%
Foster	1,185	1,105	-80	-7%
Glocester	2,526	2,664	138	6%
Hopkinton	1,839	2,011	172	9%
Jamestown	1,123	1,238	115	10%
Johnston	5,332	5,906	574	11%
Lincoln	3,890	5,157	1,267	33%
Little Compton	750	780	30	4%
Middletown	4,676	4,328	-348	-7%
Narragansett	2,869	2,833	-36	-1%
New Shoreham	163	185	22	14%
Newport	5,756	5,199	-557	-10%
North Kingstown	6,076	6,848	772	13%
North Providence	5,655	5,936	281	5%
North Smithfield	2,332	2,379	47	2%
Pawtucket	16,719	18,151	1,432	9%
Portsmouth	4,175	4,329	154	4%
Providence	37,972	45,277	7,305	19%
Richmond	1,565	2,014	449	29%
Scituate	2,426	2,635	209	9%
Smithfield	3,898	4,019	121	3%
South Kingstown	4,770	6,284	1,514	32%
Tiverton	3,166	3,367	201	6%
Warren	2,452	2,454	2	0%
Warwick	18,322	18,780	458	3%
West Greenwich	915	1,444	529	58%
West Warwick	6,560	6,632	72	1%
Westerly	4,988	5,406	418	8%
Woonsocket	10,617	11,155	538	5%
Core Cities	*75,874*	*85,313*	*9,439*	*12%*
Remainder of State	*149,816*	*162,509*	*12,693*	*9%*
Rhode Island	*225,690*	*247,822*	*22,132*	*10%*

Source of Data for Table/Methodology

U.S. Census Bureau. 1990 Census of the Population and Census 2000, Summary File 1.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[1990/2000] U.S. Bureau of the Census. Census 2000 Summary File 1.

[***] O'Hare, W. (June 2001) *The Child Population: First Data from the 2000 Census.* Baltimore, MD: The Annie E. Casey Foundation and The Population Reference Bureau.

[*] *America's Children: Key National Indicators of Well-Being* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[1990] U.S. Bureau of the Census. 1990 Census of Population.

BEST COPY AVAILABLE

Children in Single Parent Families

DEFINITION

Children in single parent families is the percentage of children under age 18 who live in families headed by a person — male or female — without a spouse present in the home. These numbers include "own children" defined as never-married children under age 18 who are related to the family head by birth, marriage, or adoption.

SIGNIFICANCE

Following the national trend, more Rhode Island children are growing up in single parent households than at any time since the census began collecting information on household living arrangements. The household in which a child lives plays a crucial role in the overall well-being of the child. Children living in single parent families are at increased risk of living in poverty compared to children living in two-parent families. In 1999, 44% of Rhode Island's single parent families with children were living below the poverty level, as compared to 4% of two-parent families with children.[1] In 1999, the average household income in Rhode Island for two-parent families with children was $72,759, compared to $38,806 for single parent families headed by a man and $29,879 for single parent families headed by a woman.[2] Of the 67,978 Rhode Island children who lived in single parent families in 2000, 83% lived in households headed by a female.[3]

Most of the 247,822 children in Rhode Island live in family households (92%).[4] Of all Rhode Island children living with at least one biological or adoptive parent, 70% lived in married couple families and the remaining 30% (67,978) lived in single-parent families.[5] About one in four (24%) White children and Asian children (26%) in Rhode Island live in single parent families, compared to 61% of Black children, 62% of American Indian children, and 53% of Hispanic children.[6] The core cities, those with child poverty rates higher than 15%, continue to have the highest rates of children living in single parent families. Overall, nearly half of all children living in the core cities live in single parent households compared to 21% in the remainder of the state.[7]

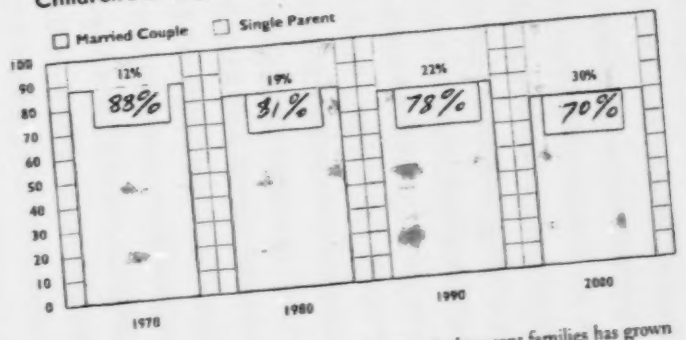
Single Parent Families

	1990	2000
RI	23%	32%
US	24%	30%
State Rank		*34th*

1st is best; 50th is worst

Source: *Children At Risk: State Trends 1999-2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Children's Living Arrangements, Rhode Island, 1970 to 2000



◇ The proportion of Rhode Island children living in single parent families has grown from 12% in 1970 to 30% in 2000.

Source: U.S. Census Bureau, 1970, 1980, 1990 and 2000 Census. Does not include children living with other relatives, unrelated individuals, or in group quarters.

The Changing Living Arrangements of Children

◇ A growing number of children live in households that include unmarried partners in which one or both may be the child's biological or adoptive parent. Although they are likely to benefit from the economic and parenting support of two adults, the U.S. Census Bureau counts these children as living in single parent households with no spouse present.[8]

◇ There are at least 1.5 million unmarried partner households with children under age 18 in the U.S.[9] Nationally, 41% of all unmarried partner households have children under age 18, just slightly less than the proportion of married couple households with children under age 18 (46%).[10]

◇ In Rhode Island, 23,180 households (6% of all households) were homes to unmarried partners. Nearly 2,500 of these households were same-sex unmarried partners.[11]

BEST COPY AVAILABLE

Table 2

Children's Living Arrangements, Rhode Island, 2000

CITY/TOWN	ALL CHILDREN LIVING IN FAMILY HOUSEHOLDS	NUMBER OF CHILDREN UNDER 18 YEARS			
		TWO-PARENT FAMILIES		SINGLE PARENT FAMILIES	
		N	%	N	%
Barrington	4,592	4,091	89%	501	11%
Bristol	4,092	3,222	79%	870	21%
Burrillville	3,737	3,077	82%	660	18%
Central Falls	4,977	2,607	52%	2,370	48%
Charlestown	1,586	1,305	82%	281	18%
Coventry	7,807	6,287	81%	1,520	19%
Cranston	15,626	11,817	76%	3,809	24%
Cumberland	7,273	6,049	83%	1,224	17%
East Greenwich	3,476	3,042	88%	434	12%
East Providence	9,682	6,919	71%	2,763	29%
Exeter	1,461	1,248	85%	213	15%
Foster	1,037	914	88%	123	12%
Glocester	2,453	2,082	85%	371	15%
Hopkinton	1,893	1,576	83%	317	17%
Jamestown	1,194	1,018	85%	176	15%
Johnston	5,440	4,303	79%	1,137	21%
Lincoln	4,895	3,930	80%	965	20%
Little Compton	740	627	85%	113	15%
Middletown	4,150	3,363	81%	787	19%
Narragansett	2,641	2,002	76%	639	24%
New Shoreham	171	139	81%	32	19%
Newport	4,835	2,723	56%	2,112	44%
North Kingstown	6,546	5,255	80%	1,291	20%
North Providence	5,411	3,973	73%	1,438	27%
North Smithfield	2,221	1,922	87%	299	13%
Pawtucket	16,525	9,537	58%	6,988	42%
Portsmouth	4,136	3,476	84%	660	16%
Providence	40,267	19,721	49%	20,546	51%
Richmond	1,867	1,590	85%	277	15%
Scituate	2,490	2,179	88%	311	12%
Smithfield	3,800	3,184	84%	616	16%
South Kingstown	5,887	4,789	81%	1,098	19%
Tiverton	3,121	2,598	83%	523	17%
Warren	2,288	1,657	72%	631	28%
Warwick	17,276	13,571	79%	3,705	21%
West Greenwich	1,368	1,198	88%	170	12%
West Warwick	6,084	4,101	67%	1,983	33%
Westerly	5,077	3,759	74%	1,318	26%
Woonsocket	10,269	5,562	54%	4,707	46%
Core Cities	*76,873*	*40,150*	*52%*	*36,723*	*48%*
Remainder of State	*151,518*	*120,263*	*79%*	*31,255*	*21%*
Rhode Island	*228,391*	*160,413*	*70%*	*67,978*	*30%*

Note to Table

The denominator is the number of children under age 18 living in family households according to the census. A family household is defined by the U.S. Census Bureau as consisting of a householder and one or more people living together in the same household who are related to the householder by birth, marriage or adoption - it may also include others not related to the householder.

Source of Data for Table/Methodology

U.S. Bureau of the Census, 2000 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[1] U.S. Bureau of the Census, Current Population Survey, 1997 to 2001 average.

[2][3][5] U.S. Bureau of the Census, Census 2000 Summary File One.

[4] The Annie E. Casey Foundation KIDS COUNT Census Data Online, http://www.aecf.org/kidscount/census (January 2002).

[6][7] *America's Families and Living Arrangements: 2000* (June 2001). Washington, DC: U.S. Census Bureau.

19

BEST COPY AVAILABLE

20

Racial and Ethnic Diversity

DEFINITION

Racial and ethnic diversity is the number of children under age 18 by racial and ethnic categories as defined by the U.S. Census Bureau for the 2000 U.S. Census of the Population. Racial and ethnic categories are selected for children by the head of household or person completing the census form.

SIGNIFICANCE

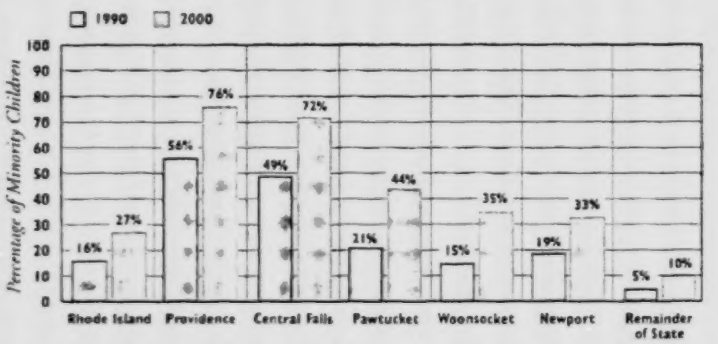
Racial and ethnic diversity has increased significantly in the United States over the last several decades. With increased immigration and higher fertility rates among minorities, diversity is projected to continue to rise in the future.[1] Nationally, minority children (all those except White, non-Hispanic children) accounted for 98% of the growth in the child population during the 1990s.[2] In 1980, nearly three quarters (74%) of all U.S. children under age 18 were White, non-Hispanic. This number had dropped to less than two-thirds (64%) in 2000. By 2020, slightly more than half (55%) of all children in the United States are projected to be White, non-Hispanic.[3]

In Rhode Island, 73% of children in the state were White, non-Hispanic in 2000 compared to 84% in 1990.[4,5] The number of minority children nearly doubled from 36,867 in 1990 to 67,747 in 2000 while the number of White, non-Hispanic children dropped by 8,748 during the same time period.[6,7] Rhode Island will become even more diverse in the next 25 years. The Census Bureau projects that by 2025, White, non-Hispanic children will be 61% of the children in the state. [8]

Outpacing census projections and growing faster than the adult population, the largest demographic increase since 1990 in the state's child population was in the number of Hispanic or Latino children. In 1990, 7% (16,107) of Rhode Island's children were of Hispanic origin. Census 2000 reported that 14% (35,002) of Rhode Island's children were of Hispanic origin. This is a 117% increase in the number of Hispanic children in the state in the last decade.[9] The number of Hispanic children in Rhode Island is expected to continue to increase to nearly 60,000 by 2025.[10]

Diversity presents opportunities and challenges to schools, child care centers, health care providers, social service agencies and other community service providers. Successful programs will need to adapt their current practices to meet the needs of a changing population.[11]

Increasing Diversity, Rhode Island and Core Cities, 1990 and 2000



Source: U.S. Bureau of the Census, 1990 Census of Population and Census 2000.

◇ In Providence and Central Falls, three-quarters of the child population is minority children. This compares with 10% of the children in the remainder of the state.[12]

◇ Minority children are highly concentrated in the core cities. Three-quarters of all the non-White children in Rhode Island reside in these five communities. Of the 85,313 children residing in the core cities, 61% are children of color.[13]

Immigration in Rhode Island

◇ In 1999, Rhode Island was home to nearly 87,600 immigrants. Of these, 6,800 were children under age 18, about 3% of all the children in the state.[14] These numbers do not include immigrants who are in the state without documentation.

Table 3.

Child Population, by Race and Ethnicity, Rhode Island, 2000

	UNDER AGE 18 BY RACE AND ETHNICITY								
CITY/TOWN	HISPANIC OR LATINO	WHITE	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN AND ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN AND OTHER PACIFIC	SOME OTHER RACE	TWO OR MORE RACES	2000 POPULATION UNDER AGE 18
Barrington	59	4,479	29	8	106	0	4	60	4,745
Bristol	88	4,183	30	3	21	4	3	67	4,399
Burrillville	59	3,915	11	8	6	0	11	33	4,043
Central Falls	3,122	1,574	292	29	22	0	225	267	5,531
Charlestown	38	1,597	7	26	12	0	1	31	1,712
Coventry	151	7,975	47	8	46	2	10	150	8,389
Cranston	1,213	14,041	513	59	796	5	71	400	17,098
Cumberland	231	7,185	65	5	70	3	38	93	7,690
East Greenwich	59	3,308	30	1	106	0	11	49	3,564
East Providence	360	8,366	681	48	114	4	323	650	10,546
Exeter	36	1,484	9	9	8	0	0	43	1,589
Foster	17	1,054	2	1	11	2	3	15	1,105
Glocester	31	2,573	15	2	10	0	1	32	2,664
Hopkinton	35	1,889	11	27	10	0	3	36	2,011
Jamestown	19	1,183	14	4	4	0	0	14	1,238
Johnston	203	5,425	63	9	93	1	21	91	5,906
Lincoln	151	4,694	73	2	116	1	21	99	5,157
Little Compton	12	756	1	0	2	0	0	9	780
Middletown	201	3,549	246	23	104	1	15	189	4,328
Narragansett	69	2,566	27	52	25	0	5	89	2,833
New Shoreham	3	175	3	0	3	0	0	1	185
Newport	602	3,485	555	86	55	7	51	358	5,199
North Kingstown	210	6,286	70	37	76	0	11	158	6,848
North Providence	377	5,033	208	12	122	3	48	133	5,936
North Smithfield	17	2,305	13	8	15	0	1	20	2,379
Pawtucket	3,820	10,090	1,776	53	131	7	1,251	1,023	18,151
Portsmouth	114	4,016	55	5	58	0	8	73	4,329
Providence	20,350	10,858	7,606	621	3,043	19	575	2,205	45,277
Richmond	32	1,916	7	19	8	0	0	32	2,014
Scituate	30	2,535	10	1	24	1	5	29	2,635
Smithfield	50	3,880	18	2	29	0	2	38	4,019
South Kingstown	128	5,561	87	126	169	0	19	194	6,284
Tiverton	46	3,234	15	4	18	0	8	42	3,367
Warren	36	2,294	38	4	11	1	6	64	2,454
Warwick	516	17,220	217	50	322	1	35	419	18,780
West Greenwich	13	1,396	4	3	7	0	5	16	1,444
West Warwick	384	5,792	86	29	102	3	26	210	6,632
Westerly	96	4,931	45	45	143	0	11	135	5,406
Woonsocket	2,024	7,272	606	29	591	5	46	582	11,155
Core Cities	*29,918*	*33,279*	*10,835*	*818*	*3,842*	*38*	*2,148*	*4,435*	*85,313*
Remainder of State	*5,084*	*146,796*	*2,750*	*640*	*2,767*	*32*	*726*	*3,714*	*162,509*
Rhode Island	*35,002*	*180,075*	*13,585*	*1,458*	*6,609*	*70*	*2,874*	*8,149*	*247,822*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2000 Redistricting File.

All categories are mutually exclusive. If Hispanic was selected as ethnicity, individuals are not included in other racial categories. Likewise, if more than one race was selected, individuals are included in two or more races and not in their individual race categories.

References for Indicator

[1] Pollard, K. and O'Hare, W. (1999). *America's Racial and Ethnic Minorities.* Washington, DC: Population Reference Bureau.

[2] O'Hare, W. (June 2001) *The Child Population: First Data from the 2000 Census.* Baltimore, MD: The Annie E. Casey Foundation and the Population Reference Bureau.

[3] *America's Children: Key National Indicators of Well-Being* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[4][5][6] U.S. Bureau of the Census, Census 2000 Summary File One.

[7] U.S. Bureau of the Census, 1990 Census of Population.

[8][9] U.S. Census Bureau, State Population Projections PE-45.

[10] *Speaking for America's Children: Child Advocates Identify Children's Issues and the 2002 State Priorities* (January 2002). Washington, DC: National Association of Child Advocates.

[11] U.S. Bureau of the Census, Current Population Survey, 1997 to 2001.

Racial and Ethnic Disparities

DEFINITION

Racial and ethnic disparities is the gap that exists in outcomes for children of different racial and ethnic groups in Rhode Island. Child well-being outcome areas include economic well-being, health, education, and safety.

SIGNIFICANCE

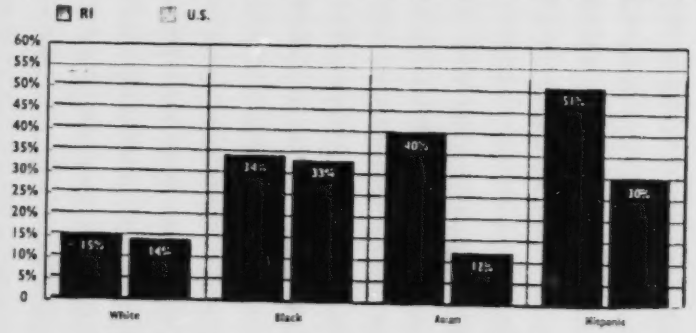
Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. Nationally, minority children accounted for 98% of the growth in the child population in the 1990s.[1] In 2000, 73% (180,075) of Rhode Island children were White, 5% (13,585) were Black, 3% (6,609) were Asian, and less than 1% (1,458) were American Indian. Of Rhode Island's 247,822 children, 14% (35,002) were Hispanic and were not included in any other race category.[2]

Although there have been substantial improvements in child well-being over the last century across racial and ethnic lines, large disparities still exist between White, non-Hispanic children and children from other racial and ethnic groups. Race and ethnicity continue to be a strong predictor of well-being in the United States and in Rhode Island.[3]

Poverty adversely impacts nearly all indicators of child well-being tracked by KIDS COUNT. Poor health interferes with a child's quality of life and educational opportunity.[4] Low educational attainment results in poor economic prospects as young people grow into adulthood and become parents themselves.[5]

Racial and ethnic minority groups continue to be disproportionately represented in the child welfare and juvenile justice systems. Research shows that minority youth are much more likely than White, non-Hispanic youth to be placed in secure detention, even when the type and severity of the offense is the same.[6] Poor families and families of color are more likely to have their child removed and placed in foster care. Once in foster care, children of color are more likely to remain there for longer periods of time and to experience multiple placements in different homes.[7] While Black, non-Hispanic children comprise 5% of the Rhode Island child population, they comprise 22% of the children in the foster care system and 26% of the youth incarcerated at the Rhode Island Training School. Hispanic children are 14% of the Rhode Island child population but represent 16% of the children in foster care and 29% of the children at the Training School.[8]

Children in Poverty, by Race and Ethnicity, Rhode Island and U.S., 1999



Note: Percentages are calculated within each racial and ethnic group.

Source: Rhode Island data are from U.S. Bureau of the Census, Current Population Survey, 1997 to 2001 average. U.S. data are from U.S. Bureau of the Census, *Poverty in the United States: 2000*. Note: Information for the Native American child population is not available.

◆ The rate of child poverty among Rhode Island's Asian children and Hispanic children is significantly higher than for Asian children and Hispanic children in the U.S. as a whole.[9] Asians and Hispanics are among the most diverse of all U.S. minority groups as they include individuals from vastly different countries of origin and varying levels of establishment in the United States depending upon time of arrival.[10]

◆ Although the majority of the poor children in Rhode Island are White, minority children are far more likely to be poor. In 1999, there were 38,611 poor children in Rhode Island. Of these, 5,477 were Black, 12,247 were Hispanic, 3,268 were Asian.[11]

◆ Children living in single parent families are much more likely to be poor. Black and Hispanic children in Rhode Island are about twice as likely to live in a single-parent family as their White and Asian counterparts. In 2000, in Rhode Island 24% of White children, 26% of Asian children, 61% of Black children, and 53% of Hispanic children lived in single parent families.[12]

BEST COPY AVAILABLE

Health Outcomes, by Race and Ethnicity, Rhode Island, 1996-2000

	WHITE	BLACK	HISPANIC	ASIAN	ALL RACES
Women with Delayed Prenatal Care	8.3%	16.0%	13.7%	15.5%	9.2%
Births to Teens Ages 15-17 (per 1,000 teens)	22	54	62	47	23
Infants Born Low Birthweight	6.7%	11.8%	7.3%	8.2%	7.3%
Infant Mortality Rate (per 1,000 live births)	5.6	12.4	7.7	6.9	6.2
Children Hospitalized for Asthma (per 1,000 children)	1.7	5.2	2.4	3.1	2.2

Source: Rhode Island Department of Health, Office of Family Health, 1996-2000 (prenatal care, teen births, low birthweight, infant mortality), and Hospital Discharge Database, 3 year average of data from 1998-2000 (asthma hospitalization).

◇ In Rhode Island, minority women are less likely to receive early prenatal care and more likely to give birth as teens. Black, Hispanic and Asian children are more likely to be born low birthweight, to die in the first year of life, to suffer from lead exposure, and/or to be hospitalized for asthma.[14]

◇ In 1999 in Rhode Island, 9% of White adults were uninsured as compared with 10% of Hispanics and 18% of Blacks.[15] Comparable data for Rhode Island children are not available. Nationally, Hispanic children and poor children are the most likely to be uninsured.[16]

Education Outcomes, by Race and Ethnicity, Rhode Island, 2000-2001

	WHITE	BLACK	HISPANIC	ASIAN	ALL RACES
Kindergarten Children with High Lead Levels (>=10ug/dL)	11%	28%	19%	19%	12%
4th Grade Children Meeting the Standard for Reading:					
Basic Understanding	81%	51%	44%	63%	71%
Analysis and Interpretation	69%	32%	27%	43%	57%
High School Graduation Rate	85%	68%	63%	78%	81%

Source: Rhode Island Department of Health Office of Occupational and Radiological Health, 2000 (lead); Rhode Island Department of Elementary and Secondary Education, 2000-2001 School Year.

◇ Black and Hispanic youth are more likely to have low reading scores by fourth grade and are more likely to drop out of high school.[17] Blacks and Hispanics are less likely to enroll in college and less likely to complete college once enrolled. In Rhode Island, 32% of White 25 to 65-year-olds hold a bachelor's degree, compared to 16% for all other races.[18]

◇ School districts in Rhode Island with the highest concentrations of minority students also have the highest rates of student mobility.[19] Nationally, children under age 5, children of color, children living in low-income households or renter households, and immigrants have the highest rates of mobility.[20] Student mobility negatively affects both the students and the schools they attend.[21]

References for Indicator

[1] O'Hare, W. (June 2001). *The Child Population: First Data from the 2000 Census.* Baltimore, MD: The Annie E. Casey Foundation.

[2] U.S. Bureau of the Census, Census 2000 Summary File One.

[3] *1999 KIDS COUNT Data Book: State Profiles of Child Well Being* (1999). Baltimore, MD: The Annie E. Casey Foundation.

[4] *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (September 1998). Washington, DC: Council of Economic Advisors for the President's Initiative on Race.

[5] Soler, M. (October 2001). *Public Opinion on Youth Crime and Race: A Guide for Advocates.* San Francisco, CA: Youth Law Center.

[6] American Bar Association (1993). *America's Children at Risk: A National Agenda for Legal Action.* Chicago, IL: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[7] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST). Foster Care Placements, December 2001 and Rhode Island Training School for Youth, December 2001.

[8-9] U.S. Bureau of the Census, Current Population Survey, 1997 to 2001.

[10] Pollard, K. and O'Hare, W. (September 1999). *America's Racial and Ethnic Minorities.* Washington, DC: Population Reference Bureau.

[11] Rhode Island Department of Health, Office of Family Health, 1996-2000.

[12] Griffin, J. (November 2001). *Profiles and Trends of the Uninsured in Rhode Island.* Cranston, RI: Rhode Island Department of Human Services.

[13] Staveteig, S. and Wigton, A. (October 2000). *Snapshots of America's Families II: Key Findings by Race and Ethnicity.* Washington, DC: The Urban Institute.

[14-15] Rhode Island Department of Elementary and Secondary Education, Infoworks 2000-2001 School Year.

[16] *Measuring Up 2000: The State-by-State Report Card for Higher Education* (2000). Washington, DC: National Center for Public Policy and Higher Education.

[17] *Geographical Mobility - Population Characteristics: March 1999 to March 2000* (May 2001). Washington, DC: U.S. Bureau of the Census.

[18] Kerbow, D. (October 1996). *Patterns of Urban Student Mobility and Local School Reform: A Technical Report.* Baltimore, MD: Johns Hopkins University.

BEST COPY AVAILABLE

Economic Well-Being

He Wishes for the Cloths of Heaven

by William Butler Yeats

Had I the heavens' embroidered cloths,
Enwrought with golden and silver light,
The blue and the dim and the dark cloths
Of night and light and the half-light,
I would spread the cloths under your feet
But I, being poor have only my dreams;
I have spread my dreams under your feet;
Tread softly because you tread on my dreams.

BEST COPY AVAILABLE

Median Household Income

DEFINITION

Median household income is the median annual income for Rhode Island households with children under age 18. The median income is the dollar amount that divides the income distribution into two equal groups – half with income above the median and half with income below the median.

SIGNIFICANCE

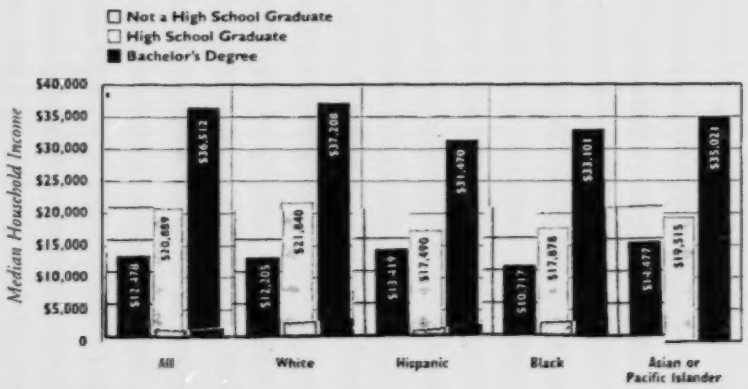
The median household income provides one measure of the ability of Rhode Island's families to meet the costs of food, clothing, housing, health care, transportation, child care, and higher education. In 1999, one-half of all Rhode Island families with children under age 18 earned less than $49,607 and one-half earned more.[1]

In 2000, U.S. median household income equaled the 1999 record high, while unemployment was at a 30-year low. Because economic growth has slowed substantially in 2001, this trend is not likely to continue.[2] Increases in median family income nationally are largely the result of increases in total work hours – an additional seven weeks annually for the typical family since 1989. With more mothers working than ever before in history, families have increased their income by having more family members working and/or by working more hours each year.[3]

Median household income levels have increased for all households in real terms between 1989 and 1999 by 5%. Black households saw the biggest increase in the median income with an increase of 14%. Hispanic household income increased by 5%.[4] Inequality still exists between incomes of U.S. households headed by those born in the country and those born elsewhere. The 2000 median household income for households headed by a person born outside the U.S. was 9% less than households headed by native-born persons.[5]

In 1999, 22% of Rhode Island households with children had incomes less than $25,000 and 9% had incomes between $25,000 and $35,000. This is down from 1995 when more of Rhode Island's families with children fell into these lowest income categories, 29% and 15% respectively.[6] Due to the tight labor market and the increase in the minimum wage, very low-paid workers experienced slight wage increases between 1996 and 1998.[7] Despite the increase in wages that began in 1996, the wages of many low-income and middle-income families have not yet returned to 1989 levels. After adjusting for inflation, in 1999 the average low-wage worker in Rhode Island had earnings that were 2% below 1989 levels.[8]

Median Earnings, by Race/Ethnic Origin and Education Level, United States, 2000



Source: *Income in 1999* (March 2000). Washington, DC: U.S. Census Bureau.

◇ Earnings increase dramatically with education level. In the U.S. in 2000, people without a high school diploma earned only two-thirds of the earnings of a high school graduate, and less than one-third of the earnings of an individual with a bachelor's degree.[9]

◆ Higher educational attainment increases earnings across all racial and ethnic categories.[10]

◆ Women with a high school diploma earn 65% more than those without one. Women continue to earn less than men across all educational levels. Women with bachelor's degrees earn only slightly more, ($29,811 annually) than men with only a high school diploma, ($26,558 annually).[11]

BEST COPY AVAILABLE

The Effects of Income Inequality

◇ Although the U.S. median income reached the highest level on record in 1999, not all families gained equally in the 1990's. In 2000, the poorest fifth of households had the lowest share of national household income in history.[9]

◇ Between the late 1980's and the late 1990's the average income of Rhode Island families in the bottom fifth of the income distribution fell by $3,781, a decline of 22%. During the same time period, the richest fifth of families saw their incomes rise by $35,146, an increase of 28%.[10]

◇ Of all 50 states, the gap between the richest 20% of families and the poorest 20% grew most in Rhode Island (followed by Oregon, Arizona, New York and Connecticut).[11]

◇ Communities with above-average inequality have higher mortality rates than communities with comparable incomes but lower inequality.[12]

◇ Increased income disparities lead to geographic segregation as wealthier families move to the suburbs. This can result in unequal school funding from property taxes.[13]

◇ Economic growth can lead to more demand for housing and higher housing prices. Family incomes at the bottom of the income distribution are not rising fast enough to keep up with the cost of housing, leading to increased risk for homelessness.[14]

Table 4.

Median Household Income, Rhode Island, 1990

CITY/TOWN	MEDIAN INCOME
Barrington	$53,058
Bristol	$34,165
Burrillville	$37,156
Central Falls	$18,617
Charlestown	$36,040
Coventry	$37,230
Cranston	$34,528
Cumberland	$40,683
East Greenwich	$50,896
East Providence	$31,007
Exeter	$38,179
Foster	$40,795
Glocester	$40,000
Hopkinton	$36,737
Jamestown	$41,518
Johnston	$32,596
Lincoln	$37,082
Little Compton	$41,187
Middletown	$35,228
Narragansett	$35,545
Newport	$30,534
New Shoreham	$31,471
North Kingstown	$40,419
North Providence	$32,321
North Smithfield	$41,449
Pawtucket	$26,541
Portsmouth	$42,474
Providence	$22,147
Richmond	$40,975
Scituate	$45,170
Smithfield	$42,523
South Kingstown	$36,481
Tiverton	$36,170
Warren	$31,637
Warwick	$35,786
Westerly	$34,844
West Greenwich	$41,250
West Warwick	$31,625
Woonsocket	$25,363
Core Cities	*NA*
Remainder of State	*NA*
Rhode Island	*$32,181*

Note to Table

In Rhode Island in 1999, the median household income for all households was $46,083 according to the U.S. Bureau of the Census, Current Population Survey, 1997-2001 average. Updated data are not available at the city/town level at the time of publication.

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population, 1989 dollars. Updated data from the 2000 Census were not available at the time of publication.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[9] U.S. Bureau of the Census, Current Population Survey, 1997 to 2001.

[10] Jaffe, J. and Bazie, M. (September 2001) *Poverty Rate Fell in 2000 As Unemployment Reached 31-Year Low.* Washington, DC: Center for Budget and Policy Priorities.

[11] Mishel, L. and Bernstein, J. (2000). *The State of Working America 2000-2001.* Washington, DC: Economic Policy Institute.

[9][10][11] *Income in 1999* (September 2000). Washington, DC: U.S. Bureau of the Census.

[9] *Money Income in the United States: 2000* (September 2001). Washington, DC: U.S. Bureau of the Census.

[9] *Low Unemployment, Rising Wages, Fuel Poverty Decline* (October 1999). Washington, DC: Center on Budget and Policy Priorities.

[10][11][12][13] Bernstein, J., McNichol, E.C., Mishel, L. et al. (January 2000). *Pulling Apart: A State-By State Analysis of Income Trends.* Washington, D.C.: Center on Budget and Policy Priorities and the Economic Policy Institute.

Cost of Rent

DEFINITION

Cost of rent is the percentage of income needed by a low-income renter to cover the average cost of rent, including heat. Rent burdens over 30% are considered unaffordable.[1] A low income renter is defined as income 30% below the 2000 median renter income.[2]

SIGNIFICANCE

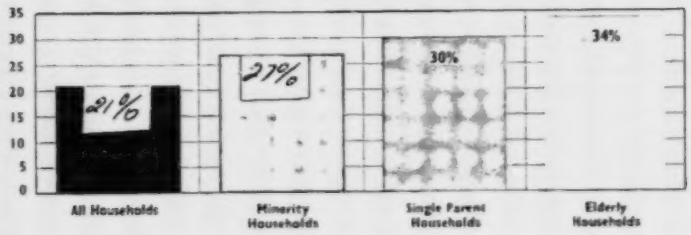
Inadequate, costly or crowded housing has a negative impact on children's health, safety, education and emotional well being.[3] Nationwide over the last three decades, the rate of families living in inadequate housing and crowded housing has slightly declined.[4] At the same time, the percentage of families with a cost burden – that is, paying more than 30% of their income for housing – rose from 15% to 28%. The percentage with severe cost burdens, paying more than half their income for housing, rose from 6% to 11%.[5]

Families with high housing costs are likely to go without other basic necessities such as food, medicine and clothing in order to pay their rent (or mortgage) and utilities.[6] Severe financial strain can hinder effective parenting, heighten conflict and contribute to the break-up of families.[7] In December of 2001, the average rent for a two-bedroom apartment in Rhode Island was $765 including heat.[8] This is more than double the $366 affordable rent for a family of three with a poverty level income.[9]

The growth in income inequality in Rhode Island over the last decade has contributed to the housing crisis for low-income and moderate-income families. Increased income inequality has led to a greater emphasis on high-end housing construction in the suburbs and luxury condominiums in urban areas.[10] Lack of construction of middle-income and low-income units statewide has increased competition for low-income housing, resulting in rising rents for often substandard housing.[11]

It is estimated that 9,900 of Rhode Island's rental units have physical defects. Eighty percent of these are located in urban communities.[12] Common housing problems include roach and rodent infestation, lead exposure, faulty wiring, inadequate heating systems, plumbing problems or lack of major appliances. Children living in substandard housing are at greater risk for injuries, fires, lead poisoning, asthma and malnutrition.[13] Research shows that there are strong links between substandard housing and educational disadvantages.[14]

Severe Housing Cost Burdens, United States, 1999



Percentage paying more than half of income for housing. Percentages are calculated within each household type.

◇ Minority and single-parent households are more likely to spend greater than 50% of their income on housing. Nearly one in three minority and single-parent households face severe cost burdens.

Source: *The State of the Nations Housing 2001* (2001). Cambridge, MA: Joint Center for Housing Research, Harvard University.

The Need for More Affordable Housing

◇ Federal housing subsidies have decreased over the last decade, expanding the affordable housing gap nationwide. In 1999, Congress restored funding for additional rental vouchers after allocating no funding between 1995 and 1998.[15]

◇ The average wait for Section 8 housing subsidies in Rhode Island is 4 to 5 years.[16] Even when Section 8 vouchers become available, families are unable to leave homeless shelters and transitional housing facilities because there are few affordable housing units for them to live in.[17]

◇ Housing prices remain out of reach for many families.[18] A worker would have to earn $12.87 per hour for forty hours per week to be able to afford a two-bedroom unit at the Fair Market Rent. This is twice the current minimum wage of $6.15 per hour.[19]

Table 5. **Cost of Rental Housing for Low-Income Families, Rhode Island, 2001**

CITY/TOWN	2001 AVERAGE RENT 2-BEDROOM	2000 LOW-INCOME RENTER	% INCOME NEEDED FOR RENT LOW-INCOME RENTER	2001 POVERTY LEVEL FAMILY OF THREE	% INCOME NEEDED FOR RENT POVERTY LEVEL FAMILY OF THREE
Barrington	$940	$19,695	57%	$14,630	77%
Bristol	$794	$19,695	48%	$14,630	65%
Burrillville	$650 *	$19,695	40%	$14,630	53%
Central Falls	$589	$19,695	36%	$14,630	48%
Charlestown	$784	$19,695	NA	$14,630	NA
Coventry	$715	$19,695	44%	$14,630	59%
Cranston	$744	$19,695	45%	$14,630	61%
Cumberland	$741	$19,695	45%	$14,630	61%
East Greenwich	$869	$19,695	53%	$14,630	71%
East Providence	$722	$19,695	44%	$14,630	59%
Exeter	$650 *	$19,695	40%	$14,630	53%
Foster	$650*	$19,695	40%	$14,630	53%
Glocester	$650*	$19,695	40%	$14,630	53%
Hopkinton	$764*	$19,695	47%	$14,630	63%
Jamestown	$1,097	$19,695	67%	$14,630	90%
Johnston	$672	$19,695	41%	$14,630	55%
Lincoln	$859	$19,695	52%	$14,630	70%
Little Compton	$650*	$19,695	40%	$14,630	53%
Middletown	$868	$19,695	53%	$14,630	71%
Narragansett	$800	$19,695	49%	$14,630	66%
Newport	$990	$19,695	60%	$14,630	81%
New Shoreham	NA	$19,695	NA	$14,630	NA
North Kingstown	$782	$19,695	48%	$14,630	64%
North Providence	$720	$19,695	44%	$14,630	59%
North Smithfield	$738	$19,695	45%	$14,630	61%
Pawtucket	$675	$19,695	41%	$14,630	55%
Portsmouth	$865	$19,695	53%	$14,630	71%
Providence	$769	$19,695	47%	$14,630	63%
Richmond	$650*	$19,695	40%	$14,630	53%
Scituate	$650*	$19,695	40%	$14,630	53%
Smithfield	$650*	$19,695	40%	$14,630	53%
South Kingstown	$742	$19,695	45%	$14,630	61%
Tiverton	$744	$19,695	45%	$14,630	61%
Warren	$646	$19,695	39%	$14,630	53%
Warwick	$757	$19,695	46%	$14,630	62%
Westerly	$704	$19,695	43%	$14,630	58%
West Greenwich	$650*	$19,695	40%	$14,630	53%
West Warwick	$707	$19,695	43%	$14,630	58%
Woonsocket	$653	$19,695	40%	$14,630	54%
Core Cities	*$735*	*$19,695*	*45%*	*$14,630*	*60%*
Remainder of State	*$770*	*$19,695*	*47%*	*$14,630*	*63%*
Rhode Island	*$765*	*$19,695*	*47%*	*$14,630*	*63%*

Source of Data for Table/Methodology

Rhode Island Housing and Mortgage Finance Corporation, January-December 2001 Rent Survey. A low-income renter is defined as 30% below the 2000 median renter income. Median renter income for 2001 was not available. Average rents are based on a survey of rents in Rhode Island between January and December 2001. Rents include the HUD allowance for heat, if heat was not included in the advertised rent.

*Rhode Island Housing 2001 Rent Survey data are not available for these communities. Average rent used for these communities is the HUD 2001 Fair Market Rents, as reported in *Out of Reach 2001* (September 2001). Washington, DC: National Low-Income Housing Coalition.

References for Indicator

[1,2] *Out of Reach 2001: America's Growing Wage-Rent Disparity* (September 2001) Washington, DC: National Low Income Housing Coalition.

[3,4,5,6] *The State of Rhode Island Consolidated Plan FY 2001 – 2005* (January 2000). Providence, RI: Rhode Island Housing and Mortgage Finance Corporation.

[7,8] *America's Children: Key National Indicators of Well-Being, 2001* (July 2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[9,10] Sherr, R. (October 2000). *Our Basic Dream: Keeping Roots with America's Working Families and Their Children.* New York, NY: Foundation for Child Development.

[11] Rhode Island KIDS COUNT calculations using data from Rhode Island Housing and Mortgage Finance Corporation.

[12,13,14] Hirsch, E. (2001) *Rhode Island's Housing Crisis.* Providence, RI: Providence College.

[15] *Not Safe as Home: How America's Housing Crisis Threatens the Health of Children* (February 1998). Boston, MA: The Doc4Kids Project, Boston Medical Center and Children's Hospital.

[16] *The State of the Nation's Housing 2001* (2001). Cambridge MA: Joint Center for Housing Research, Harvard University.

BEST COPY AVAILABLE

Secure Parental Employment

DEFINITION

Secure parental employment is the percentage of children living with at least one parent who has full-time, year-round employment.

SIGNIFICANCE

Secure parental employment is a strong determinant of whether or not children will be poor. In 1999, 88% of all non-poor children in the U.S. had at least one parent with full-time year round employment, compared to only 31% of poor children.[1] Secure parental employment can have positive impacts on child well-being that go beyond reducing poverty and increasing median household income. Children with parents who have steady employment are more likely to have access to health care and stable, regular child care.[2] Secure parental employment is also likely to improve family functioning by reducing the stress brought on by unemployment and underemployment of parents.[3] In Rhode Island in 2000, there were approximately 75,000 Rhode Island children whose parents did not have secure parental employment.[4]

Following overall employment trends, the percentage of parents with secure employment nationally has increased since 1984 when only 69% of all children lived with at least one parent with full-time, full-year employment.[5] In 2000, 69% of all children in Rhode Island lived in families with secure parental employment, comparable to the national rate of 72%.[6] The level of secure parental employment varies significantly by race and ethnicity, family structure, and age of children. In 1999, 64% of Black, non-Hispanic children and 71% of Hispanic children had a parent working full-time, full-year in contrast to 84% of White, non-Hispanic children.[7] Overall, older children were more likely than younger children to live in households with one fully-employed parent.[8]

Secure Parental Employment

	1990	2000
RI	70%	69%
US	71%	72%
State Rank		*37th*

1st is best; 50th is worst

Source: *Children At Risk: State Trends 1990-2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

The Federal Earned Income Tax Credit

◇ The federal Earned Income Tax Credit (EITC) is a refundable credit on the federal income tax, available since 1975 to low-income and moderate-income working families with children.

◇ 4.8 million people, including 2.6 million children, were lifted above the poverty line as a result of the federal EITC. The EITC removes more children from poverty than any other federal program.[9]

◇ According to a national study, low-income Hispanic parents are less than half as likely as low-income non-Hispanic parents to know about the Earned Income Tax Credit. Current welfare recipients are less likely than past welfare recipients to know about the program. Outreach to families eligible for the EITC has increased participation nationally.[10]

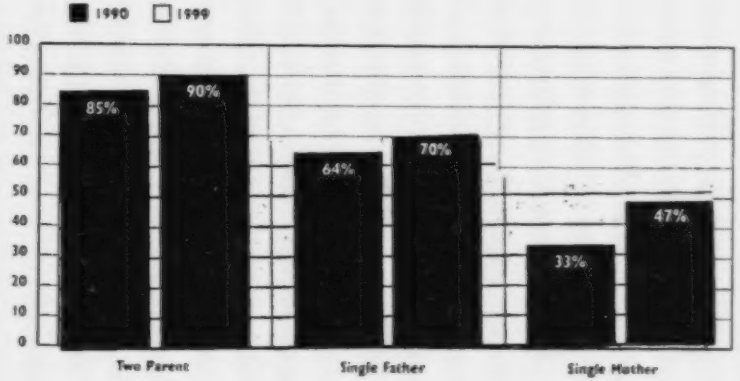
Rhode Island's Earned Income Tax Credit

◇ The state of Rhode Island is one of sixteen states that have established a state EITC program that helps to bring low-wage workers out of poverty. In 1999, there were 58,000 Rhode Island low-income working families that received the EITC.[11]

◇ Rhode Island's EITC is non-refundable so that it provides no cash benefit to working families that have incomes too low to owe state income taxes. When a state EITC is refundable, the family receives a refund check if the size of its EITC exceeds its tax bill. In 2000, two-parent families of four in Rhode Island had no state income tax liability until they reached $25,900.[12]

◇ Refundable EITC programs exist in 11 states and maximize economic benefits to the lowest-income families.[13] A refundable state EITC would contribute an additional $14 million to the budgets of low-income working families in the Providence area alone and $4.7 million to the economy of the city of Providence.[14]

Secure Parental Employment by Family Structure, United States, 1990 and 1999



◇ Even with sharp increases in the number of single mothers with secure parental employment in the last half on the 1990's, only 47% of single mother families had full-time, full-year employment in 1999. This compares to 70% of single father families with secure employment and 90% of two-parent households that had at least one parent securely attached to the labor force in 1999.

Source: *America's Children: Key National Indicators of Well-Being* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

Minimum Wage Laws

◇ Rhode Island is one of 16 states with minimum wage laws. In 2001, the Rhode Island minimum wage was $6.15 per hour.[15]

◇ Working 40 hours per week, 52 weeks per year, a parent working at minimum wage would be unable to earn enough to raise a family of three above the federal poverty level. In 1999, half of Rhode Island families with incomes below the poverty line were headed by a parent that worked full-time or part-time.[16]

◇ Living wage proposals are directed at a specific workforce and set wage rates higher than minimum wage laws. In 2001, an ordinance was introduced to the Providence city council that would require the city of Providence, large city contractors and employers receiving substantial tax breaks to pay a minimum of $10.19 per hour and the equivalent of $1.78 for health insurance benefits.[17]

◇ There are more than 40 jurisdictions in the U.S., including Boston, Hartford and New Haven, that have passed living wage ordinances.[18]

References

[1,2,3,7] *America's Children: Key National Indicators of Well-Being* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[4,6] *KIDS COUNT Data Book* (2001). Baltimore, MD: The Annie E. Casey Foundation.

[5] *Trends in the Well-Being of America's Children and Youth* (2000). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[8,9,10,11] Johnson, N. (November 2001). *A Hand Up: How State Earned Income Tax Credits Help Working Families Escape Poverty in 2000*. Washington, DC: Center on Budget and Policy Priorities.

[12] Phillips, K.R. (January 2001). *Who Knows About the Earned Income Tax Credit?* Washington, DC: The Urban Institute.

[13] *Rewarding Work: The Impact of the Earned Income Tax Credit in Greater Providence* (June 2001). Washington, DC: Center on Urban and Metropolitan Policy, The Brookings Institution.

[15] U.S. Department of Labor, Minimum Wage Laws in the States, www.dol.gov/dol/esa/public/minwage/america/htm (January 2002).

[16] U.S. Bureau of the Census, Current Population Survey, 1997 to 2001 average.

[17] Rhode Island Jobs with Justice (January 2002).

[18] *Living Wage Laws: Answers to Frequently Asked Questions* (October 2000). Washington DC: AFL-CIO Department of Public Policy.

BEST COPY AVAILABLE

Children Receiving Child Support

DEFINITION

Children receiving child support is the percentage of non-custodial parents in the Rhode Island Child Support Enforcement System who pay child support on time and in full. The percentage does not include cases in which paternity has not been established. Court orders for child support require establishment of paternity.

SIGNIFICANCE

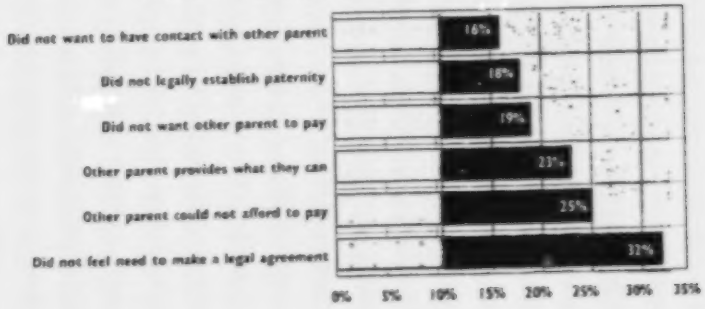
The receipt of child support payments can make significant improvements in the economic status of a child growing up in a family with a non-resident parent. Child support lifts a half million children from poverty in the U.S. each year.[1] When poor families receive child support, the child support averages 26% of the family's budget, making it the second largest source of income next to earnings.[2]

The goal of the child support system is to collect money from non-custodial parents so that their children can have adequate financial security as they grow up. For child support to be collected on behalf of a child, the non-custodial parent must be identified, paternity must be established, a support order must be entered, and the money must be collected.[3] Failure of a non-custodial parent to pay child support has significant economic consequences for the custodial parent and for the child. Nationally, children who live with one parent are nearly four times as likely to be poor as children who live with both parents.[4]

In 2000, nearly 68,000 Rhode Island children lived in a single parent family.[5] Of the Rhode Island families headed by a single female, only 28% received child support or alimony payments in 1998, compared to 34% nationally. This is one of the lowest rates of child support or alimony in the country.[6]

Even when there is a child support order in place, child support payments tend to be low and unreliable. As of December 2001, there were 93,932 Rhode Island children in the State's Child Support Enforcement System.[7] Of these, 20,302 (22%) have not yet had paternity established and therefore are not yet eligible for a child support award.[8] In 2001 in Rhode Island, 45% of non-custodial parents under court order paid child support on time and in full; this is an increase from 40% in 1999.[9] As of December 31, 2001, the amount of past due court-ordered child support in Rhode Island totaled $171 million.[10]

Reasons No Legal Child Support Agreement Established for Custodial Parents, United States, 1998



Based on data from 6.6 million custodial parents without agreements or with informal agreements. Excludes those with pending agreements. Total exceeds 100% because respondents could list more than one reason.

◇ Of the 13.9 million custodial parents in the U.S. in 1998, 6.0 million (43%) have no legal agreements for the payment of child support. An additional 600,000 (4%) have informal agreements or understandings for payments in place.

◇ 7.2 million custodial parents (52%) have a legal agreement in place for payment of child support.

◇ Among the parents with legal child support agreements, only 41% received all of their child support payments. One in four parents (27%) with agreements received some, but not all, of what was due.

◇ Low-income mothers, Black or Hispanic mothers, never-married mothers, and mothers with less than a college education are least likely to receive the child support due under court order.

Source: *Child Support for Custodial Mothers and Fathers, 1997* (October 2000). Washington, DC: US Census Bureau.

BEST COPY AVAILABLE

Child Support and the Family Independence Program

◇ In order to receive cash benefits through the Family Independence Program (FIP), custodial parents are required to cooperate with the Rhode Island Department of Administration's Child Support Enforcement Division in establishing paternity and seeking child support.[11]

◇ When there has been domestic violence the requirement to establish paternity and seek child support may be waived in order to protect the custodial parent. Caseworkers are required to notify FIP applicants and recipients of this waiver option.[12]

◇ As of December 2001 in Rhode Island, 62% (17,935) of the 28,884 children enrolled in the Family Independence Program were in the Child Support Enforcement System and had paternity established.[13]

◇ The average child support obligation to children enrolled in FIP is $216 per month, as compared to an average child support obligation of $269 per month for non-FIP families.[14]

◇ 3,200 families in Rhode Island receive a $50 child support pass-through. The first $50 of child support paid on behalf of a child receiving cash assistance goes to the custodial parent caring for the child. The pass-through occurs only if the child support payments are received on-time and in-full.[15]

Non-Custodial Fathers, United States, 1997

◇ More than half of all non-poor fathers do not pay child support. For every poor father who does not pay child support, there are nearly two non-poor fathers who do not pay.[16]

◇ Ninety percent of all poor fathers do not pay child support.[17] Many non-custodial parents are poor themselves, lack job experience, and have limited education. Child support is more likely to be paid when enforcement strategies are combined with job training, job retention support, and transportation assistance for the non-custodial parent.[18]

◇ Parents who have regular contact with their children are more likely to pay child support. In 1997 in the United States, 73% of parents who had either joint custody or visitation privileges paid child support compared to 36% who did not have regular contact.[19]

References for Indicator

[11] Sorenson, E. and Zibman, C. (March 2000). *Child Support Offers Some Protection Against Poverty.* Washington, DC: The Urban Institute.

[12] Turetsky, V. (May 2001). *Families Participating in the State Child Support Program.* Washington, DC: Center for Law and Social Policy.

[13] *Giving Hope and Support to America's Children: Handbook on Child Support Enforcement.* Washington, DC: U.S. Department of Human Services, Administration for Children and Families, Office of Child Support Enforcement.

[14] U.S. Bureau of the Census, Census 2000 Summary File 1

[15] *KIDS Count Data Book: State Profiles of Child Well-Being 2001* (2001). Baltimore, MD: The Annie E. Casey Foundation.

[16] [17] [18] Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, December 1, 2001. Also see methodology on page 123.

[19] *Paternity: Questions Moms Usually Ask and Their Answers.* Providence RI: State of Rhode Island and Providence Plantations.

[16] Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, December 2001, and the Rhode Island Department of Human Services InRhodes Database, December 2001.

[17] Rhode Island Department of Human Services (January 2002). DHS SFY 2002 Budget Supplemental Summary of Major Points.

[17] [18] Sorenson, E. and Zibman, C. (April 2001). *Poor Dads Who Don't Pay Child Support: Deadbeats or Disadvantaged?* Washington, DC: The Urban Institute.

[19] Sorenson, E. and Zibman, C. (September 2000). *A Look At Poor Dads Who Don't Pay Child Support.* Washington, DC: The Urban Institute.

[19] *Child Support for Custodial Mothers and Fathers: 1997* (October 2000). Washington, DC: U.S. Census Bureau.

Children in Poverty

DEFINITION

Children in poverty is the percentage of related children under age 18 who live in families below the poverty threshold, as defined by the U.S. Office of Management and Budget. "Related children" include the family head's children by birth, marriage and adoption, as well as other persons under age 18 who are related to and live with the family head, such as nieces and nephews.

SIGNIFICANCE

Children most at risk of not achieving their full potential are children in poverty, regardless of race.[1] Poverty is related to every KIDS COUNT indicator. Children in poverty are more likely to have difficulty in school, to become teen parents and to earn less as adults.[2] Children in low-income communities are more likely to attend poorly equipped schools; have less access to libraries and cultural activities; have limited access to high quality child care programs; and have fewer opportunities to participate in sports and recreations programs after school and in the summer.[3,4]

Single parenthood, low educational attainment, part-time or no employment and low wages of parents place children at risk of being poor.[5] Family economic conditions in early and middle childhood appear to be more important for shaping ability and achievement than do economic conditions during adolescence.[6] Efforts that improve the quality of a child's environment, especially in the early years of life, can produce lifelong impacts on learning, social skills, and mental health.[7]

There is considerable movement into and out of poverty each year.[8] Those living with incomes close to the poverty line are vulnerable to becoming poor due to changes in employment, housing and utility costs, life changes such as the birth of a child, changes in marital status and illness or disability.[9]

Children in Poverty

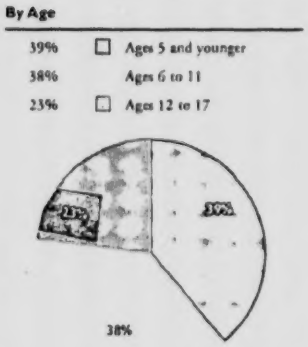
	1990	2000
RI	14%	17%
US	18%	17%
State Rank		*30th*

1st is best; 50th is worst

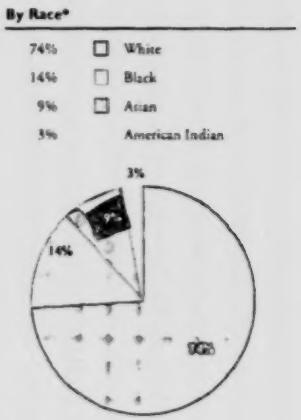
Source: *Children at Risk: State Trends 1990-2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Rhode Island's Poor Children, 1999

By Age

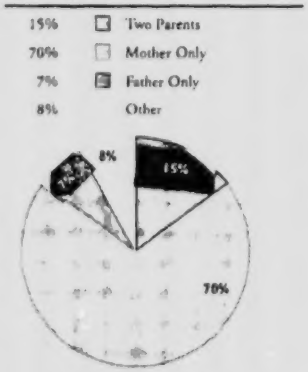


By Race*



**Hispanic children may be included in any race category. Of Rhode Island's 38,611 poor children, 32% are Hispanic.*

By Family Structure



◇ In 1999, there were 38,611 poor children in Rhode Island, 18% of all Rhode Island children. In 2001, the official poverty level for a family of four was $17,650.[10]

Source: U.S. Bureau of the Census, Current Population Survey, 1997 to 2001 average.

BEST COPY AVAILABLE

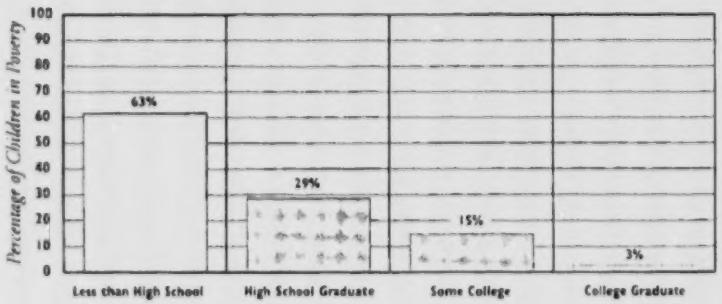
Young Children Under Age 6 in Poverty in Rhode Island

◇ In 1999, one in five (20%) Rhode Island children under 6 was living in poverty, compared to 18% nationally.[11,12] There were 15,057 children under age 6 living in families with incomes below the poverty line.[13,14]

◇ As of December 1, 2001 there were 11,673 young children under age 6 in families receiving cash assistance from the Family Independence Program. Of all children in the Family Independence Program, 40% were under age 6.[15]

◇ Research shows that the quality of a child's environment and social interactions in the early years affect brain development, producing lifelong impacts on learning, social skills and mental health.[16]

Young Children Under Age 6 in Poverty, by Educational Level of More Educated Parent, United States, 1997



◇ In 1997, almost two-thirds (63%) of young children whose parents did not graduate from high school were poor. Almost one-third (29%) of young children whose parents did not undertake education beyond high school were poor.

Source: National Center for Children in Poverty (June 1999). *Young Children in Poverty: A Statistical Update*. New York, NY: Columbia University, Joseph Mailman School of Public Health.

Children Living in Extreme Poverty

◇ Families with income below 50% of the federal poverty level are considered to be living in extreme poverty.[17] The extreme poverty level in 2001 is family income below $8,825 for a family of four.[18]

◇ Nationally, the percentage of children living in extreme poverty doubled from 5% to 10% between 1975 and 1993.[19] In 1999, 6% of U.S. children lived in extreme poverty.[20]

◇ In 1998, nearly 25,000 children in Rhode Island lived in extreme poverty. This was 10% of all Rhode Island children and more than half of all poor children in Rhode Island.[21]

◇ Young children and children of color are more likely to live in extreme poverty. In the U.S., one in ten children under age 6 is extremely poor.[22] In 1999, 15% of Black children, 11% of Hispanic children, and 3% of White, non-Hispanic children lived in extreme poverty.[23]

◇ Although the overall poverty rate fell in the last decade in the U.S. as a whole, those who remain in poverty have become poorer. Average incomes for those below the poverty level have dropped to the lowest levels in 20 years. After taking into account the value of non-cash benefits and the Earned Income Tax Credit, the average income of a person living in poverty fell $2,527 below the poverty line in 2000, in contrast to $2,048 in 1989 and $2,059 in 1979.[24]

◇ Children who live in poverty for multiple years and children who live in extreme poverty experience the worst outcomes as a result of their family's income status.[25] Programs that raise the income of poor families are likely to enhance the cognitive development of children and improve their chance of success in the labor market in adulthood.[26]

Building Blocks of Economic Security

Income Supports for Working Families

◇ Earnings from full-time work in low-wage jobs or participation in cash assistance alone will leave a family with income below the poverty level. In 1999, 54% of Rhode Island families with children with incomes below the poverty line worked full-time or part-time, up from 41% in 1993.[27] Participation in work support (or income support) programs can provide the necessary resources to lift a family above the poverty line.[28]

◇ Work supports are programs and services that enable working families to sustain employment and provide a reasonable standard of living for their families. Work supports include Earned Income Tax Credits, child care subsidies, health insurance, adult education and training, Food Stamps, housing assistance, transportation, and child support.[29]

◇ In Rhode Island, the Family Independence Program (FIP) allows families to work while receiving cash assistance. Working at least 30 hours a week at $6.15 an hour while receiving FIP cash assistance, food stamps, and the Earned Income Tax Credit provides a family income above the poverty level.[30]

Access to Health Care

◇ Many workers in low-wage jobs are not offered or cannot afford employer-sponsored health insurance. Access to health insurance improves the likelihood of having a regular and accessible source of health care.[31]

◇ RIte Care, Rhode Island's managed care program for low-income families, has been successful at insuring poor children. Rhode Island has the lowest rate (5%) of uninsured children in the country. Yet, in 2000 there were 12,000 children in the state with working parents who lacked health insurance.[32]

High Quality Child Care

◇ The quality and stability of the child care setting is critical to a parent's ability to work and to the child's development.[33] Child care costs represent a significant part of the budget of low-income families and are associated with a mother's refusal or termination of employment.[34]

◇ Rhode Island is the only state in the country with an entitlement to child care subsidies for income-eligible families. The number of children receiving child care subsidies has nearly doubled since the Family Independence Act was implemented, increasing from 6,065 in 1997 to 12,682 in 2001.[35]

Affordable Housing

◇ Stable housing is a critical requirement for job retention and performance. Low-income adults with unstable housing situations are less likely to find and keep a job.[36]

◇ In 2001, the average rent for a two-bedroom apartment in Rhode Island was $765 including heat. This is more than double the $366 rent that is considered affordable for a family of three with a poverty level income and more than the $492 rent that would be affordable to a low-income renter.[37]

Educational Attainment

◇ Individuals with higher education generally have more job opportunities, higher wages and greater job security than those with lower levels of education.[38]

◇ Rhode Island's investment in adult education and training for welfare recipients, while delaying the rapid caseload declines seen in other states, is beginning to demonstrate positive results. Those who leave welfare in Rhode Island are less likely to be poor, more likely to be employed, and more likely to retain employment than former welfare recipients nationally.[39,40,41]

Table 6. **Child Poverty, Rhode Island, 1990**

	CHILDREN UNDER 18 BELOW POVERTY		CHILDREN UNDER 6 BELOW POVERTY	
CITY/TOWN	N	%	N	%
Barrington	52	1.3%	33	2.6%
Bristol	253	5.9%	128	8.3%
Burrillville	276	6.1%	119	8.5%
Central Falls	1,576	32.5%	749	38.0%
Charlestown	145	9.4%	39	6.4%
Coventry	402	5.3%	180	7.3%
Cranston	1,378	9.5%	562	10.9%
Cumberland	302	4.7%	151	7.4%
East Greenwich	153	5.3%	112	13.0%
East Providence	904	8.7%	355	9.9%
Exeter	52	3.6%	5	1.0%
Foster	88	7.6%	0	0.0%
Glocester	156	6.5%	77	10.0%
Hopkinton	75	4.1%	9	1.4%
Jamestown	92	8.1%	45	11.9%
Johnston	452	8.4%	187	10.6%
Lincoln	272	7.0%	98	7.2%
Little Compton	20	2.7%	15	5.1%
Middletown	275	6.0%	158	9.1%
Narragansett	122	4.5%	36	3.6%
Newport	1,143	20.3%	575	27.0%
New Shoreham	17	10.1%	6	10.0%
North Kingstown	281	4.7%	121	6.1%
North Providence	298	5.4%	78	4.3%
North Smithfield	37	1.6%	19	3.1%
Pawtucket	2,525	15.5%	1,096	17.3%
Portsmouth	182	4.4%	70	5.2%
Providence	12,946	34.5%	5,531	36.8%
Richmond	30	2.0%	0	0.0%
Scituate	91	3.7%	19	2.3%
Smithfield	155	4.1%	61	4.9%
South Kingstown	350	7.5%	133	8.7%
Tiverton	200	6.4%	81	7.9%
Warren	199	8.5%	56	6.2%
Warwick	1,084	5.9%	448	7.2%
Westerly	432	8.7%	224	12.9%
West Greenwich	26	2.9%	11	4.2%
West Warwick	746	11.8%	291	13.0%
Woonsocket	2,235	21.4%	1,034	26.9%
Core Cities	*20,425*	*27.3%*	*8,985*	*30.7%*
Remainder of State	*9,597*	*6.5%*	*3,927*	*7.9%*
Rhode Island	*30,022*	*13.5%*	*12,912*	*16.3%*

Source of Data for Table/Methodology

Data are from the U.S. Bureau of the Census, 1990 Census of the Population. Poverty data from the 2000 Census were not available at time of publication.

References for Indicator

[1] Children's Defense Fund (1994). *Wasting America's Future: The Children's Defense Fund Report on the Costs of Child Poverty in America.* Boston: Beacon Press.

[2,3,4,5,6,7,8,9] *America's Children: Key Indicators of Well Being* (2001). Washington, DC: U.S. Federal Interagency Forum on Child and Family Statistics.

[3,10] *Years of Promise: A Comprehensive Strategy for America's Children* (1996). New York, NY: Carnegie Corporation.

[4] Jargowsky, P. (1997). *Poverty and Place: Ghettos, Barrios and the American City.* New York, NY: Russell Sage Foundation.

[5,12] *Young Children in Poverty: A Statistical Update.* (June 1999). New York, NY: National Center for Children in Poverty, Columbia University.

[6] Duncan G.J. and Moscow L. (1997). "Longitudinal Indicators of Children's Poverty and Dependence" in Hauser, R. et. al. (eds.) *Indicators of Children's Well-Being.* New York, NY: Russell Sage Foundation.

[7] *One in Four* (1996). New York, NY: National Center for Children in Poverty, Columbia University.

[8,9] O'Hare, W.P. (September 1996). "A New Look at Poverty in America" in *Population Bulletin, Vol 51.* Washington DC: The Population Reference Bureau.

[10,11] *The 2001 HHS Poverty Guidelines* (2001). Washington DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

[11,12,13,17] US Bureau of the Census, Current Population Survey, 1997 to 2001 average.

[13,15] Rhode Island Department of Human Services, InRhodes Database, December 2001.

[14] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York, NY: Carnegie Corporation; and Shore, R. (1997). *Rethinking the Brain.* New York, NY: Families and Work Institute.

[15,16,18] *Trends in the Well Being of America's Children and Youth* (2000). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

[21] *KIDS COUNT Databook: State Profiles of Child Well Being* (2001). Baltimore, MD: The Annie E. Casey Foundation.

[19] *Poverty Rates Fell in 2000 as Unemployment Reached 31-Year Low* (September 2001). Washington, DC: Center on Budget and Policy Priorities.

[20] Duncan, G. and Brooks-Gunn, J. eds. (1997). *Consequences of Growing Up Poor.* New York, NY: Russell Sage Foundation.

[23] *The 2001 Rhode Island Standard of Need* (2001). Providence RI: The Poverty Institute at Rhode Island College.

[22] Fishman, M. and Beebout, H. (December 2001). *Supports for Working Poor Families: A New Approach.* The Lewin Group and Mathematica, Inc.

[24,25] A&M Consulting (February 2002). *Rhode Island's Family Independence Act: Research Demonstrates Wisdom of Putting Families First.* Cranston, RI: Rhode Island Department of Human Services.

[26] US Bureau of the Census, Current Population Survey, 1999 to 2001 average compiled by KIDS COUNT, The Annie E. Casey Foundation.

[28] Smith, K. (October 2000). *Who's Minding the Kids? Childcare Arrangements.* Washington, DC: U. S. Bureau of the Census.

[29] *The Value of Housing Subsidies to Welfare Reform Efforts* (February 2000). Washington, DC: Center on Budget and Policy Priorities.

[27] Rhode Island KIDS COUNT calculations using data from Rhode Island Housing and Mortgage Finance Corporation.

[30] *A Study of Welfare Reform and Rhode Island's Beneficiaries* (November 2001). Providence, RI: Rhode Island College.

[31] *Factors Affecting Rhode Island's Welfare Caseload Reduction* (March 2001). Providence, RI: Rhode Island Public Expenditure Council and The Poverty Institute.

Children in the Family Independence Program

DEFINITION

Children enrolled in the Family Independence Program is the percentage of children less than age 18 who were living in families receiving cash assistance through the Family Independence Program (FIP) on December 1, 2001. These data measure the number of children and families enrolled in FIP at one point in time. They do not count the additional children and families who qualified for the program at other points in the year but were not enrolled on December 1, 2001.

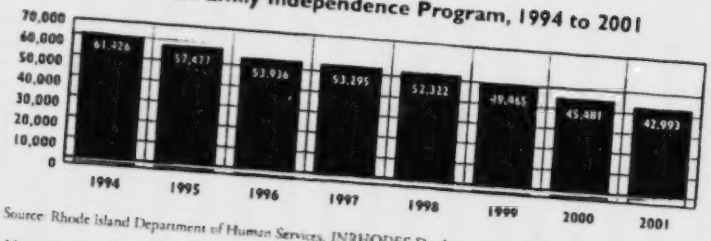
SIGNIFICANCE

Rhode Island's Family Independence Program seeks to help families make successful transitions to work by providing the work supports, including health insurance and subsidized child care, that families need to obtain and keep a job. The Family Independence Program allows two-parent and single-parent families to obtain cash assistance. The program provides work incentives by allowing working recipients to keep more of their earnings before cash assistance is decreased or terminated.[1]

If a family has no earned income, the maximum monthly FIP benefit for a Rhode Island family of three is $554 per month. With an additional $336 per month in Food Stamps, the monthly combined benefit is $890.[2] This amount is 73% of the federal poverty level.[3] While cash benefits alone do not lift families out of poverty, they provide minimal subsistence for poor families. When combined with earned income and the Earned Income Tax Credit, cash assistance can move a family working full-time at minimum wage above the federal poverty line of $14,630 for a family of three.[4] As of December 1, 2001 in Rhode Island, 2,799 of the adults receiving FIP cash assistance were employed.[5] The average wage for employed FIP recipients is $7.88 per hour.[6]

More than two-thirds (68%) of all FIP beneficiaries are children under the age of 18.[7] Five of every six children receiving cash assistance through FIP are ages 12 and under.[8] As of December 1, 2001, there were 29,177 Rhode Island children in families receiving cash assistance through the Family Independence Program.[9] In the core cities as a whole (Providence, Pawtucket, Central Falls, Woonsocket and Newport), 26% of children live in families that receive cash assistance through FIP compared to 4% of children in the remainder of the state.[10] This is a decrease from 1996, when 31% of children in the core cities lived in families receiving cash assistance.[11]

Adults and Children Enrolled in AFDC/Family Independence Program, 1994 to 2001



Source: Rhode Island Department of Human Services, INRHODES Database, 1994 to 2001

Note: Prior to May 1, 1997, the Family Independence Program was AFDC (Aid to Families with Dependent Children). More than two-thirds of FIP recipients are children under age 18.

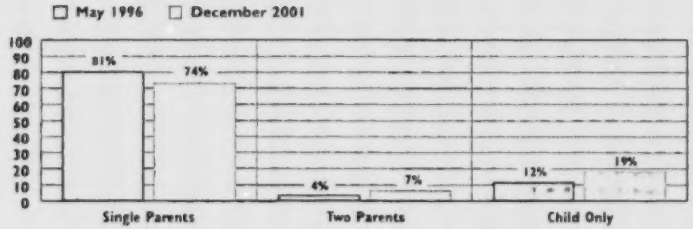
◇ In 2001, there were 42,993 adults and children in Rhode Island enrolled in the Family Independence program.[12] This is a 30% decline in cash assistance recipients since 1994, compared to a decline of 58% for the U.S. as a whole.[13]

◇ Rhode Island has experienced a more gradual caseload reduction than other states because of a set of policies that were designed to help families make an effective transition from welfare to work including: the earned income disregard which supplements the wages of low-income workers, a slower start-up while families developed employment plans required by law, and policies that enable families to develop job skills through education and training.[14]

◇ FIP has nearly doubled the likelihood of parents being employed when compared to its predecessor, the AFDC program.[15] With the implementation of the FIP program, the percentage of families with working adults increased from 18% of all cases in May 1996 to 37% of all cases in April 2000.[16] Nearly half (45%) of all adults with work requirements and FIP employment plans were participating in work, education or training as of December 2001.[17]

BEST COPY AVAILABLE

Trends in Family Structure, Families Enrolled in the Family Independence Program, 1996-2001



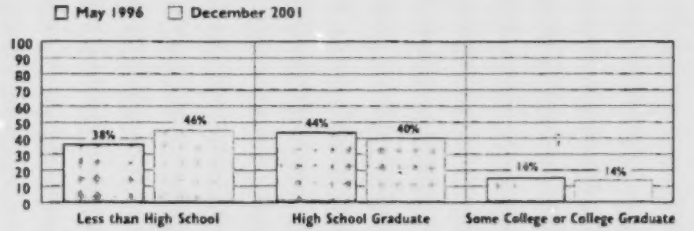
Source: Witte, A.D. and Queralt, M. (2001). *Study of The Cash Assistance Program May 1996 - April 2000* and Rhode Island Department of Human Services, December 2001. Note: May not equal 100% due to missing data. In 1996 there were 21,382 cases. In 2001 there were 14,990 cases.

◇ Two-parent families are eligible for cash assistance if they meet the income eligibility guidelines.[18] Since the implementation of the FIP program in May 1996, there has been an increase in the percentage of two-parent families receiving cash assistance, from 4% (828 families) of all cases in 1996 to 7% (1,029 families) of all cases in 2001.[19,20]

◇ Child-only cases have increased from 12% of all cases in May 1996 to 19% of all cases in December 2001.[21] Child only cases are those that receive cash assistance only for the children in the family because the child is living with a grandparent or other non-parent relative, the parent is disabled and receiving Supplemental Security Income, the parent is not a U.S. citizen, or the parent is under sanction for non-compliance with a program requirement.[22]

◇ It is likely that the percentage of all cases that are child only cases will continue to increase as adults in the family reach five-year time limits beginning in Rhode Island in June 2002.[23] Through FIP, children in families that are income-eligible are entitled to cash assistance without time limits. A five-year time limit for cash benefits is placed on adults in the family. The five-year time limit excludes any time period when the adult in the family worked at least 30 hours a week for single-parent families or 35 hours per week for two-parent families.[24]

Trends in Education Level, Families Enrolled in the Family Independence Program, 1996-2001



Source: Witte, A.D. and Queralt, M. (2001). *Study of The Cash Assistance Program May 1996 - April 2000* and Rhode Island Department of Human Services, December 2001 (excludes child only cases). Note: May not equal 100% due to missing data.

◇ There is evidence in Rhode Island and nationally that families still receiving cash assistance generally have more serious barriers to employment than those who have left assistance.[25,26] Cases in which the head of household has less than a high school education has increased from 38% of cases in May 1996 to 46% of cases in December 2001.[27,28]

◇ Since 1996 in Rhode Island, cases in which the head of household speaks a language other than English as a first language has increased as a percentage of the total caseload. In 2001 nearly one in five (19%) heads of families enrolled in the FIP program speaks Spanish as their primary language, compared to 14% in 1996.[29,30]

◇ A Rhode Island study indicates that families still enrolled in cash assistance are more likely to report transportation barriers to work and training.[31] They are more likely to have children with health and developmental problems (mental health, short-term illness, chronic illness, school attendance, behavior, learning disabilities, and developmental disabilities) and to miss work or training activities due to their children's needs.[32]

Children in the Family Independence Program

Elements of Effective Welfare Reform

Assists families in obtaining sustainable jobs that move them out of poverty and into economic self-sufficiency.

◇ Low-income working families require adequate income to meet their needs for housing, food, clothing, health insurance, child care, and transportation.

◇ The Rhode Island Standard of Need, developed by the Poverty Institute at Rhode Island College, approximates the income a family needs to pay for basic living expenses. The Standard of Need is the hourly wage that a single parent with two children needs to adequately provide for the family's basic living expenses. The 2001 Rhode Island Standard of Need is $19.50 per hour.[33] With the benefit of work supports such as child care subsidies, health insurance, and the Earned Income Tax Credit, the RI Standard of Need for a single parent with two children is $10.55.[34]

◇ The Family Independence Program (FIP) permits adults receiving cash assistance to postpone employment for up to 24 months in order to get necessary education or basic skills training to be workforce ready.

◇ One evaluation of the FIP has found that adults who opted for training or education before they looked for jobs were far more likely to be employed and had family earnings on average $90 per month higher than before the training. Parents who completed education and training while enrolled in FIP had higher hourly wages ($8.48 per hour) compared to those who did not complete education and training ($7.38 per hour).[35]

Supports the healthy development of children and provides access to a range of supports needed by low-income families.

◇ Access to affordable health insurance is critical to a parent's ability to work and to healthy child development. More than two-thirds of children enrolled in RIte Care, Rhode Island's Medicaid managed care program, live in low-income working families.[36] Rhode Island has the lowest rate of uninsured children in the country.[37]

◇ Participation in high quality child care promotes school readiness and healthy child development, especially among low-income children.[38] National studies show that among mothers of all income levels, higher cost child care is associated with a higher probability of refusing or terminating employment.[39] Rhode Island's investments in child care are critical to a family's ability to successfully transition from welfare to work.

◇ Under current work participation rate provisions, states are generally unable to count individualized "barrier removal" activities toward meeting participation rates. However, families with substantial barriers to employment (such as physical or mental impairments, depression, domestic violence, learning disabilities, or substance abuse) may need specific services before they are able to meet work requirements and/or undertake education and training.

Children in the Family Independence Program

Table 7.

Children Enrolled in the Family Independence Program (FIP), Rhode Island, December 1, 2001

CITY/TOWN	CHILDREN UNDER 18	NUMBER RECEIVING FIP CASH ASSISTANCE: FAMILIES	NUMBER RECEIVING FIP CASH ASSISTANCE: CHILDREN	FIP CHILDREN AS % OF ALL CHILDREN UNDER 18
Barrington	4,745	24	31	1%
Bristol	4,399	85	143	3%
Burrillville	4,043	72	121	3%
Central Falls	5,531	872	1,775	32%
Charlestown	1,712	40	66	4%
Coventry	8,389	178	282	3%
Cranston	17,098	707	1,136	7%
Cumberland	7,690	100	160	2%
East Greenwich	3,564	45	71	2%
East Providence	10,546	428	741	7%
Exeter	1,589	25	41	3%
Foster	1,105	11	19	2%
Glocester	2,664	29	50	2%
Hopkinton	2,011	38	63	3%
Jamestown	1,238	9	9	1%
Johnston	5,906	209	344	6%
Lincoln	5,157	83	140	3%
Little Compton	780	3	4	1%
Middletown	4,328	75	112	3%
Narragansett	2,833	58	96	3%
New Shoreham	185	2	3	2%
Newport	5,199	481	957	18%
North Kingstown	6,848	165	257	4%
North Providence	5,936	236	380	6%
North Smithfield	2,379	20	30	1%
Pawtucket	18,151	1,739	3,118	17%
Portsmouth	4,329	37	52	1%
Providence	45,277	7,175	14,405	32%
Richmond	2,014	24	35	2%
Scituate	2,635	28	37	1%
Smithfield	4,019	31	43	1%
South Kingstown	6,284	122	229	4%
Tiverton	3,367	65	87	3%
Warren	2,454	72	135	6%
Warwick	18,780	509	813	4%
West Greenwich	1,444	18	27	2%
West Warwick	6,632	404	666	10%
Westerly	5,406	161	265	5%
Woonsocket	11,155	1,168	2,234	20%
Core Cities	*85,313*	*11,435*	*22,489*	*26%*
Remainder of State	*162,509*	*4,113*	*6,688*	*4%*
Rhode Island	*247,822*	*15,548*	*29,177*	*12%*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, INRHODES Database, December 2001.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the total number of children under age 18 in 2000 according to the 2000 Census of the U.S. population.

References for Indicator

[illegible] *Rhode Island's Family Independence Program, Annual Report* (2001). Cranston, RI: Rhode Island Department of Human Services.

[illegible] Rhode Island Department of Human Services, INRHODES Database, December 1, 2001.

[illegible] Rhode Island Department of Human Services, INRHODES Database. Calculations by Rhode Island KIDS COUNT.

[illegible] *Comments to the U.S. Department of Health and Human Services Regarding the Reauthorization of the TANF Block Grant* (November 2001). Washington, DC: Center for Law and Social Policy.

[illegible] Rhode Island Public Expenditure Council and The Poverty Institute (March 2001). *Factors Affecting Rhode Island's Welfare Caseload Reduction.* Providence: RI.

[illegible] A &M Consulting (February 2002). *Rhode Island's Family Independence Act: Research Demonstrates Wisdom of Putting Families First.* Cranston, RI: Rhode Island Department of Human Services.

[illegible] Witte, A.D. and Queralt, M. (August 2001) *Study of The Cash Assistance Program May 1996 - April 2000.* Wellesley, MA: Wellesley College.

[illegible] The Poverty Institute: Rhode Island College School of Social Work, February 2002.

[illegible] Current Population Survey, 1999-2001. Calculations by the Annie E. Casey Foundation.

[illegible] Cauthen, N.K. and Knitzer, J. (1999). *Children and Welfare: Issue Brief #6. Beyond Work: Strategies to Promote the Well-Being of Young Children and Their Families.* New York, NY: National Center for Children in Poverty.

[illegible] *Access to Child Care for Low-Income Working Families* (1999). Washington, DC: U.S. Department of Health and Human Services.

[illegible] *Comments to the U.S. Department of Health and Human Services Regarding the Reauthorization of the TANF Block Grant* (November 2001). Washington, DC: Center for Law and Social Policy.

Children Receiving Food Stamps

DEFINITION

Children receiving food stamps is the percentage of income-eligible children under age 18 who participate in the Food Stamp program.

SIGNIFICANCE

The Food Stamp program provides monthly benefits to low-income households that can be used for the purchase of food at retail stores. Food Stamps provide important nutrition benefits to low-income families who are at high risk for undernutrition and poor health.[1]

The Food Stamp program is an entitlement, meaning that federal funding is provided to all applicants who meet the eligibility requirements. Unlike cash assistance for adults through the Family Independence Program, participation in Food Stamps is not time-limited and can be used as long as the person or family meets the eligibility requirements.[2,3] Many of Rhode Island's documented immigrants qualify for food stamp benefits.[4] Rhode Island is one of 13 states that has state-funded food stamps for some immigrants who are no longer eligible for federally-funded food stamps.[5] There are approximately 2,200 Rhode Islanders currently receiving these state-funded benefits.[6]

One of the strengths of the Food Stamp program is its flexibility. The program is structured to respond to changes in need brought on by economic cycles or natural emergencies.[7] The benefit level for each eligible household is adjusted according to income. Nearly one in five Food Stamp cases in Rhode Island have some earned income.[8] The monthly benefit level decreases as household income increases. Many working families do not realize that they are eligible for Food Stamps.[9]

The maximum monthly Food Stamp benefit for a Rhode Island family of three is $356. The average monthly benefit for a family of three in the state is $218, a decrease from the 1997 monthly average of $270.[10] As of October 1, 2001 there were 36,871 children in Rhode Island who received benefits from the Food Stamp program. Half of all Food Stamp recipients in Rhode Island are children under age 18.[11] Nationally households with children receive 87% of all Food Stamp benefits.[12] Food Stamp participation has significantly declined since 1994.[13] As the number of families using the Food Stamp program has decreased, food pantries and emergency food banks have seen their service numbers rise.[14]

Food Stamp Participation

◇ The Food Stamp program is the central component of U.S. national policy to reduce hunger and food insecurity. Yet, in 1998 only 59% of those eligible for Food Stamps in the U.S. were enrolled. This is a decrease from 1994 when 71% of those eligible were enrolled.[15]

◇ In 1998 in Rhode Island, the USDA estimated that between 62% and 78% of people who were eligible for the Food Stamp program participated.[16]

◇ Although the number of Rhode Island children enrolled in the Food Stamp program has dropped by 16% since 1996, the number of income-eligible children (based on eligibility for the free School Lunch program) has remained relatively constant.[17]

◇ Eligibility for Food Stamps requires that households meet both an income guideline (less than 130% of the federal poverty level) and an assets test – which considers resources such as cash, bonds, stocks, automobile ownership, etc. The resource limit is $2,000 per household ($3,000 for a person age 60 or older). The home in which a family lives and a car worth less than $4,650 is not counted. Only certain immigrants are eligible for Food Stamps.[18]

◇ There are an estimated 74,882 children who are income-eligible for Food Stamps based on School Lunch enrollment numbers across the state.[19] In October 2001, there were 36,871 children receiving Food Stamp benefits.[20] This is 49% of all income-eligible children. Some children who live in families that meet the income-eligibility requirement will not meet the assets test that is part of determining eligibility for Food Stamps.[21]

Table 8. **Children Under Age 18 Receiving Food Stamps, Rhode Island, October 1, 2001**

CITY/TOWN	ESTIMATED NUMBER INCOME-ELIGIBLE	NUMBER PARTICIPATING	% OF INCOME-ELIGIBLE PARTICIPATING
Barrington	119	34	29%
Bristol	911	187	21%
Burrillville	480	170	35%
Central Falls	4,310	2,194	51%
Charlestown	164	85	52%
Coventry	905	360	40%
Cranston	2,902	1,399	48%
Cumberland	682	202	30%
East Greenwich	175	114	65%
East Providence	2,458	982	40%
Exeter	138	45	33%
Foster	103	28	27%
Glocester	204	57	28%
Hopkinton	193	92	48%
Jamestown	54	21	39%
Johnston	843	469	56%
Lincoln	437	193	44%
Little Compton	38	23	61%
Middletown	493	136	28%
Narragansett	271	105	39%
New Shoreham	14	10	71%
Newport	2,102	1,238	59%
North Kingstown	648	357	55%
North Providence	995	480	48%
North Smithfield	140	32	23%
Pawtucket	10,524	4,123	39%
Portsmouth	197	86	44%
Providence	32,496	17,857	55%
Richmond	193	62	32%
Scituate	133	52	39%
Smithfield	168	72	43%
South Kingstown	500	254	51%
Tiverton	350	122	35%
Warren	508	180	35%
Warwick	2,318	1,089	47%
West Greenwich	126	26	21%
West Warwick	1,651	810	49%
Westerly	757	411	54%
Woonsocket	5,182	2,714	52%
Core Cities	*54,614*	*28,126*	*51%*
Remainder of State	*20,268*	*8,745*	*43%*
Rhode Island	*74,882*	*36,871*	*49%*

Source of Data for Table/Methodology

Estimated number eligible is based on the total number of children ages birth to 18 from the 2000 U.S. Census multiplied by the % of students eligible for free School Lunch in each community. Families with incomes less than 130% of poverty are income-eligible for free School Lunch. Income eligibility for Food Stamps is also set at 130% of poverty but that program has an additional assets test as part of eligibility determination. This table shows children who are likely to meet the income-eligibility requirements for Food Stamps – some will not qualify for the program because the household does not meet the assets test required by the Food Stamp program.

Free School Lunch percentages are from the Rhode Island Department of Education, October 2000. Food Stamp program participation data are from the Rhode Island Department of Human Services, INRHODES Database, October 1, 2001. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

References for Indicator

[1] Cook, J.T. (May 1998). *The Importance of the Food Stamp Program for Low-Income Legal Immigrants.* Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[2] *Hunger in America: America's Second Harvest's Third National Hunger Study* (2001). Washington, DC: America's Second Harvest.

[3,4,5] *The Poverty Institute Guide to Government Assistance Programs 2001* (September 2001). Providence, RI: The Poverty Institute at Rhode Island College School of Social Work.

[6] *State Governments Responses to the Food Assistance Gap* (2000). Washington, DC: Food Research and Action Center and America's Second Harvest.

[7,8] Rhode Island Department of Human Services, INRHODES Database, December 1, 2001.

[9,12] *Federal Food Programs: Food Stamp Program Frequently Asked Questions.* Food Research and Action Center website. www.frac.org (January 2002).

[9,10,11] *The Decline Food Stamp Participation: A Report to Congress* (July 2001). Washington, DC: U.S. Department of Agriculture, Food and Nutrition Service.

[10,13,14] Rhode Island Department of Human Services, INRHODES Database, October 1, 2001.

[10,15] Schirm, A. (January 2001). *Reaching Those In Need. State Food Stamp Participation Rates in 1998.* Washington, DC: USDA and Mathematica Policy Research, Inc.

[11,12] Rhode Island KIDS COUNT estimates based on Census 2000 and information from the Rhode Island Department of Elementary and Secondary Education for October 2000.

Children Participating in School Breakfast

DEFINITION

Children participating in school breakfast is the percentage of low-income public school children who eat breakfast provided through the School Breakfast Program. Children are counted as low-income if they are eligible for and enrolled in the free or reduced price school meal program.

SIGNIFICANCE

Undernutrition during any period of childhood can have a detrimental impact on a child's cognitive development. The longer a child's nutritional needs go unmet, the greater the risk of cognitive impairment.[1] Students who eat breakfast have significantly higher math scores, fewer absences, improved attentiveness and lower incidences of social and behavioral problems.[2]

Low-income students are more likely than other students to arrive at school without an adequate breakfast.[3] The School Breakfast Program offers nutritious meals to children at participating schools, providing children with one-fourth or more of their Recommended Daily Allowance for key nutrients.[4]

Many children need access to School Breakfast Programs because their parents cannot afford to provide a nutritious breakfast each day. In Rhode Island, one in three households with children did not have enough food to meet basic needs at all times during the year in 2000.[5] Rhode Islanders who have children under the age of 6, are single parents, have not finished high school, or are Hispanic are the most likely to report that they did not have enough food to meet their basic needs.[6] For other children, long commute times and rushed family schedules make having time for eating breakfast before school difficult and put children at a disadvantage in their ability to concentrate and arrive in class ready to learn.[7]

Federal and state funds are available to support the costs of the School Breakfast Program. To receive a reduced price meal, household income must be below 185% of the federal poverty level. For free meals, household income must fall at or below 130% of the poverty level. Children in Food Stamp and Family Independence Program households are automatically eligible for free school meals.[8] In October 2001, an average of 15,340 school breakfasts were served daily across Rhode Island. Of these, 92% were served to low-income children eligible for free or reduced price meals.[9]

School Breakfast Access and Participation

◇ Rhode Island has led the country in the increase in the number of schools participating in the School Breakfast Program for three years in a row.[10] In 1995, almost two-thirds (62%) of Rhode Island public schools did not offer the breakfast program.[11] As of 2000, all Rhode Island schools participate in the School Breakfast Program. Rhode Island is one of only five states in the country to have state legislation that requires all public schools to provide students with access to school breakfast.[12]

◇ Rhode Island is still among the worst in the country (46th) for the rate of student participation in the School Breakfast Program.[13] On average, only 27% of all children eligible for free or reduced price lunch participated in the breakfast program in 2001.[14] The states with the best participation rates are serving breakfast to about 55% of low-income children.[15]

◇ The expansion of School Breakfast Programs to all children without regard to income eligibility can significantly improve the number of low-income children who access the program.[16] Other strategies for increasing participation include informing parents and children of eligibility, providing transportation, and involving parents in the program.

◇ Central Falls and Providence offer universal free school breakfast to every student in the public schools and Cranston currently has the universal free breakfast program in eight schools. Efforts are currently underway to develop universal free School Breakfast Programs in the remaining core cities.[17]

Table 9. **Children Participating in the School Breakfast Program, Rhode Island, 2001**

SCHOOL DISTRICT	2000 FALL ENROLLMENT	DISTRICT WIDE AVERAGE DAILY PARTICIPATION IN BREAKFAST	PERCENT OF ALL CHILDREN RECEIVING BREAKFAST	NUMBER OF LOW-INCOME STUDENTS	LOW-INCOME AVERAGE DAILY PARTICIPATION IN BREAKFAST	PERCENT OF ALL LOW-INCOME CHILDREN RECEIVING BREAKFAST
Barrington	2,079	3	<1%	79	2	3%
Bristol-Warren	3,650	232	6%	1,026	189	18%
Burrillville	2,757	141	5%	496	83	17%
Central Falls	3,489	981	28%	3,064	841	27%
Chariho	3,736	77	2%	513	58	11%
Coventry	5,329	310	6%	832	181	22%
Cranston	10,692	906	9%	2,295	691	30%
Cumberland	4,953	203	4%	604	132	22%
East Greenwich	2,336	29	1%	124	20	16%
East Providence	6,411	383	6%	1,977	340	17%
Exeter-W. Greenwich	1,973	61	3%	234	40	17%
Foster	365	38	10%	51	22	43%
Foster-Glocester	1,597	31	2%	100	16	16%
Glocester	720	11	2%	87	7	8%
Jamestown	616	6	1%	35	3	9%
Johnston	3,203	141	4%	567	122	22%
Lincoln	3,473	166	5%	412	151	37%
Little Compton	325	1	<1%	29	-	0%
Middletown	2,817	98	3%	499	85	17%
Narragansett	1,650	24	2%	216	21	10%
Newport	3,018	538	18%	1,391	516	37%
New Shoreham	129	9	7%	12	9	75%
North Kingstown	4,325	207	5%	551	155	28%
North Providence	3,460	177	5%	703	150	21%
North Smithfield	1,778	20	1%	154	10	6%
Pawtucket	9,698	1,388	14%	6,622	1,388	21%
Portsmouth	1,955	46	2%	137	33	24%
Providence	26,878	6,492	24%	20,810	6,492	31%
Scituate	1,609	22	1%	129	14	11%
Smithfield	2,605	77	3%	148	37	25%
South Kingstown	4,207	129	3%	442	106	24%
Tiverton	2,128	77	4%	331	46	14%
Warwick	12,126	632	5%	2,096	481	23%
West Warwick	3,614	365	10%	1,146	282	25%
Westerly	3,533	164	5%	655	164	25%
Woonsocket	6,546	1,155	18%	3,656	1,155	32%
Core Cities	*49,629*	*10,554*	*21%*	*35,543*	*10,392*	*29%*
Remainder of State	*100,151*	*4,786*	*5%*	*16,680*	*3,650*	*22%*
Rhode Island	*149,780*	*15,340*	*10%*	*52,223*	*14,042*	*27%*

Note to Table

This table is different from previous Factbooks in that it measures the percentage of *students participating* in the School Breakfast Program (i.e., eating breakfast in school) rather than the percentage of *schools offering* breakfast.

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, October 2001. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Half-day kindergarten, private schools and residential child care facilities may offer the School Breakfast Program, but are not included in these calculations.

Fall enrollment is the public school enrollment as of October 1, 2000. Average daily participation in breakfast is the number of students eating a school breakfast on average in the month of October 2001. Number of low-income students is the number of students eligible for and enrolled in free or reduced price school meal programs in the month of October 2000. Low-income average daily participation in breakfast is the number of students eligible for and enrolled in free or reduced price school meal programs who also ate breakfast in school on average in the month of October 2001.

The denominator is the number of children enrolled in the public school system who are eligible for and enrolled in free or reduced price school meal programs in the Fall of 2000, not including half-day kindergarten.

References for Indicator

[1] *Statement on the Link Between Nutrition and Cognitive Development in Children* (1998). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

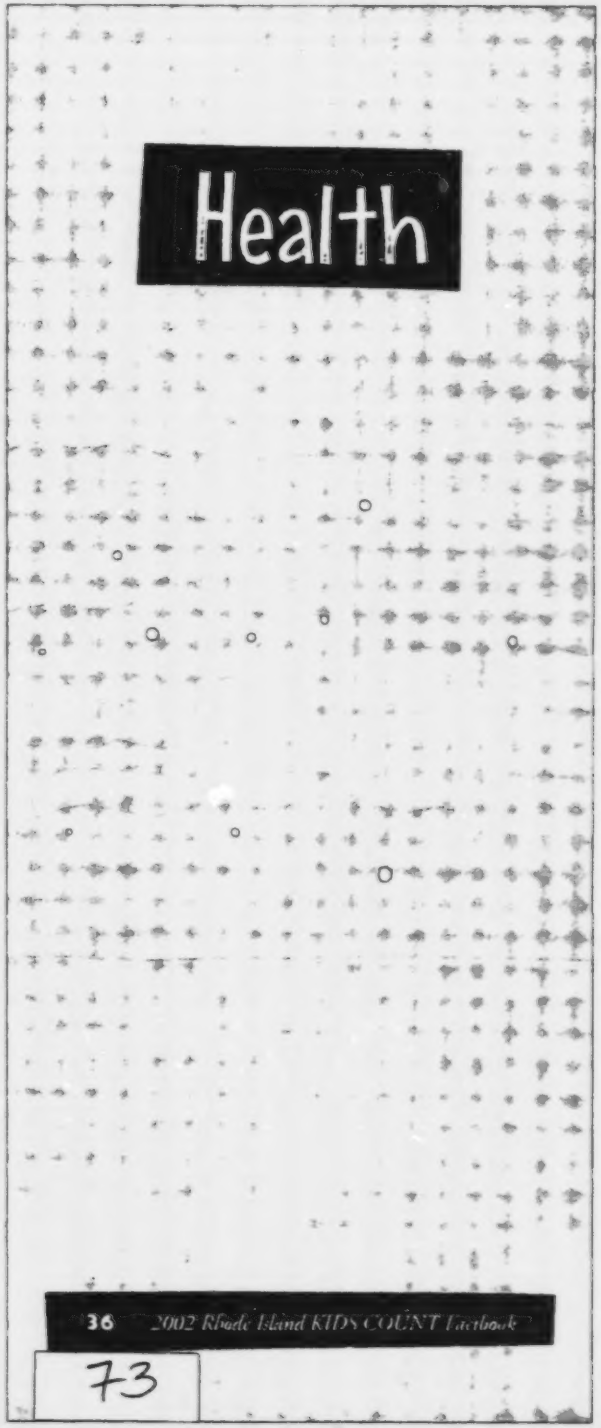
[2,4,5,7,8,11,14] *School Breakfast Scorecard 2001: FRAC's Annual Status Report on the School Breakfast Program* (2001). Washington, DC: Food Research and Action Center.

[3] *The Rhode Island Food Security Monitoring Project: Assessing the Prevalence of Hunger and Food Insecurity in Rhode Island Year 2000 Summary Report* (January 2001). Providence, RI: Rhode Island Department of Health, Division of Family Health.

[6,9,10] Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, Fall 2002.

[12,13] *State of the States: A Profile of Food and Nutrition Programs Across the Nation* (December 2000). Washington, DC: Food Research and Action Center.

[15] The George Wiley Center, Pawtucket, Rhode Island, February 2002.



73

To a Red Kite

by Lilian Moore

Fling
yourself
upon the sky.

Take the string
you need.
Ride high,

high, above the park.
Tug and buck
and lark
with the wind.

Touch a cloud,
red kite.
Follow the wild geese
in their flight.

BEST COPY AVAILABLE

76
75

Children's Health Insurance

DEFINITION

Children's health insurance is the percentage of children below age 19 who are covered by any kind of public or private health insurance, including Medicaid during the previous calendar year. These data reflect only those who were uninsured through the entire year and do not include those who were insured for only part of the year.

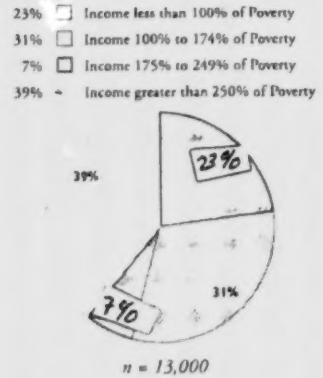
SIGNIFICANCE

Children's health insurance status is a major determinant in whether children have access to care. Children who lack insurance coverage are more likely to be sick as newborns, less likely to be immunized as preschoolers, and less likely to receive medical treatment for injuries.[1] Insured children are more likely than uninsured children to receive medical care for common conditions like asthma and ear infections – illnesses that if left untreated can have life-long consequences and lead to more serious health problems.[2,3]

A parent's employment-related insurance coverage and eligibility for medical assistance are the most important factors in determining whether children have health insurance coverage and the type of coverage.[4] As the unemployment rate rises, it is likely that more children will lose coverage from their parents' employer-sponsored health insurance.[5]

RIte Care/RIte Share, Rhode Island's Medicaid managed care program, is available to children in families with incomes up to 250% of the federal poverty line ($36,575 for a family of three). Low-income parents of eligible children can enroll if family income is less than 185% of the federal poverty line ($27,065 for a family of three). Of the 117,185 RIte Care members enrolled as of December 31, 2001, two-thirds (76,379) were children under age 19. There were 21,453 low-income parents enrolled in RIte Care as of December 31, 2001.[6]

Children Under Age 19 without Health Insurance, by Poverty Level, Rhode Island, 2000



n = 13,000

Source: U.S. Bureau of the Census, Current Population Survey, 1999-2001 average. Compiled by The Annie E. Casey Foundation.

Uninsured Children in Rhode Island, 2000

◇ As of 2000, 5% of Rhode Island's children under age 19 were uninsured, compared to 14% nationally. Rhode Island has the lowest rate of uninsured children in the country.[7] The rate of uninsured children in Rhode Island has been reduced by half over the past five years.[8]

◇ The rates of uninsured children in Pawtucket, Central Falls and Providence are greater than the state average of 5%. In Pawtucket, 10% of children are uninsured and in Providence 7% of children are uninsured.[9] In Central Falls 7% of children are uninsured, down from 13% in 1997.[10]

◇ As of 2000, an estimated 8,000 Rhode Island children were eligible for RIte Care but uninsured.[11] Most (92%) of Rhode Island's uninsured children live in working families.[12]

RIte Care Program Changes

◇ RIte Share, Rhode Island's health insurance premium assistance program, began implementation in April 2001. RIte Share requires RIte Care applicants with access to employer-sponsored insurance to participate in their employer's insurance plan. RIte Share pays the employee's share of the cost for enrolling in an approved employer-sponsored family or individual health insurance plan.[13]

◇ Eligibility guidelines are the same as for RIte Care, i.e., the employee must have a RIte Care-eligible family member in order to enroll in RIte Share.[14] RIte Share provides the full range of RIte Care benefits to families by covering RIte Care services not included in the employer's health plan.[15]

◇ Beginning in January 2002, families participating in RIte Care with incomes above 150% of poverty ($21,945 for a family of three) pay a monthly family premium. The premium ranges from $43 to $58 depending on family income.[16]

BEST COPY AVAILABLE

Table 10

Children Under Age 19 Receiving Medical Assistance, Rhode Island, December 2001

CITY/TOWN	Rite Care FIP	Rite Care Non-FIP	SSI	Other	Total
Barrington	42	126	8	48	224
Bristol	172	451	15	41	679
Burrillville	129	435	19	115	698
Central Falls	1,956	2,151	138	21	4,266
Charlestown	82	218	9	25	334
Coventry	321	849	35	148	1,353
Cranston	1,247	2,457	121	234	4,059
Cumberland	193	619	25	112	949
East Greenwich	79	166	6	44	295
East Providence	845	1,659	79	133	2,716
Exeter	45	139	1	37	222
Foster	28	78	0	32	138
Glocester	52	202	4	63	321
Hopkinton	76	234	5	12	327
Jamestown	12	64	1	19	96
Johnston	408	903	37	53	1,401
Lincoln	161	469	25	67	722
Little Compton	6	56	1	3	66
Middletown	124	399	20	51	594
Narragansett	110	264	14	71	459
Newport	1,032	1,047	66	78	2,221
New Shoreham	3	22	1	0	26
North Kingstown	294	633	26	84	1,037
North Providence	424	836	39	88	1,387
North Smithfield	38	127	7	39	211
Pawtucket	3,511	4,531	319	170	8,531
Portsmouth	59	306	7	62	434
Providence	15,658	13,995	1,257	2,740	33,650
Richmond	47	130	10	32	219
Scituate	57	232	2	47	338
Smithfield	55	253	5	49	362
South Kingstown	250	506	33	79	868
Tiverton	98	319	9	21	447
Warren	150	358	12	31	551
Warwick	889	2,422	118	264	3,693
West Greenwich	31	114	3	23	171
West Warwick	746	1,264	63	90	2,163
Westerly	310	765	25	47	1,147
Woonsocket	2,418	2,339	214	174	5,145
Out-of-State	*73*	*16*	*54*	*1*	*144*
Unknown	*202*	*172*	*1,396*	*51*	*1,821*
Core Cities	*24,575*	*24,063*	*1,992*	*3,183*	*53,813*
Remainder of State	*7,583*	*18,075*	*785*	*2,264*	*28,707*
Rhode Island	*32,433*	*42,326*	*4,227*	*5,499*	*84,485*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, MMIS Database, December 31, 2001. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The column labeled "Rite Care/FIP" is the number of children enrolled in Rite Care as of December 31, 2001 who also participate in the Family Independence Program. "Rite Care, Non-FIP" includes all other Rite Care participants under the age of 19 and pregnant women. "SSI" is children enrolled in fee-for-service Medicaid because they receive SSI. "Other" includes children in DCYF out-of-home placements (foster care) and non-SSI children with disabilities who are enrolled in fee-for-service Medicaid. "Other" also includes 1,899 children in DCYF out-of-home placements (foster care) who are enrolled in Rite Care under an initiative begun with DCYF in November 2000. The Providence numbers may include foster children who live in other towns, because the DHS database lists foster children as Providence residents for administrative purposes.

References for Indicator

[1] Edmunds, Margaret and Molly Joel Coye (1998). *America's Children: Health Insurance and Access to Care*. Washington, DC: National Academy Press.

[2] *Uninsured in America: A Chartbook*. (May 2000). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

[3] *The March of Dimes Data Book for Policy Makers: Maternal, Infant, and Child Health in the US* (2001). Washington, DC: March of Dimes, Office of Government Affairs.

[4] "Health Insurance Coverage" in *The Future of Children* Vol 5, No. 3 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[5] *Rising Unemployment and the Uninsured*. (January 2002). Washington, DC: Kaiser Family Foundation.

[6] Rhode Island Department of Human Services, MMIS Database, December 31, 2001.

[7,11,14] US Bureau of Census, Current Population Survey, 1999-2001 average. Compiled by The Annie E. Casey Foundation.

[8] U.S. Bureau of the Census, Current Population Survey, 1992-1996 average and 1999-2001 average.

[9,10] RI Department of Human Services, Medicaid Data Archive and Rhode Island Department of Health, Behavioral Risk Factor Surveillance System, 1996 and 1998 average and 1999-2000 average.

[12,13,15] *Health Reform Rhode Island 2000: Rite Care Stabilization Implementation Plan* (August 2000). Cranston, RI: Rhode Island Department of Human Services.

[16] Medical Assistance Program in accordance with R.I.G.L. 40-8.4-13, to Establish Cost Sharing Requirements for Certain Families and Individuals Applying for or Receiving Medical Assistance. (August 2001). Cranston, RI: Rhode Island Department of Human Services.

Access to Dental Care

DEFINITION

Access to dental care is the percentage of children under age 21 who are enrolled in RIte Care or Medicaid fee-for-service who have received dental prevention or treatment services during state fiscal year 2000 (July 1, 1999 through June 30, 2000).

SIGNIFICANCE

Dental caries (tooth decay) is the most common disease among children 5 to 17 years old.[1] Children who receive an inadequate level of dental care or no dental care at all can develop long-term oral health problems and are more likely to experience dental conditions that require emergency treatment.[2] Preschool children with untreated dental caries are more likely to develop poor eating habits, to have difficulty socializing with peers, and to have speech problems. Children with poor dental health are at increased risk for future dental caries in their permanent teeth.[3] Chronic dental problems in school-age children and adolescents can lead to poor self-image, lack of concentration, absenteeism, and reduced school performance.[4]

Children without dental insurance are three times as likely as privately-insured children to be unable to access dental care when needed.[5] In 1999 in Rhode Island, fewer than half (45%) of employers offered dental insurance as a benefit.[6] National estimates indicate that for every child without medical insurance there are 2.6 children without dental insurance.[7] Minority families, low-income families, and families with low education levels are the most likely to be uninsured for dental care.[8] In 1996, 31% of Rhode Island children under age 5 and 26% of children between ages 6 and 18 were uninsured for dental services.[9]

For children in low-income families, the efficacy of public dental insurance is a critical factor in access to dental prevention and treatment.[10] Barriers to obtaining oral health services for children insured through RIte Care or Medicaid include difficulty finding a dental provider who will accept Medical Assistance coverage, inadequate financial resources to pay for dental care, and lack of parental education on the need for dental prevention and treatment services.[11] Obtaining services from dental specialists is especially difficult for children covered through public health insurance programs.[12] Children with disabilities or special health care needs may also have problems accessing providers that are equipped to address their special needs.[13]

Children's Access to Dental Care

◇ Approximately 63% of the total U.S. child population see a dentist annually.[14]

◇ Despite the entitlement to dental services under Medicaid EPSDT, only one in five children (21%) enrolled in Medicaid in the U.S. has received a single dental visit over the course of one year.[15]

◇ Of all Rhode Island children under age 21 enrolled in RIte Care or Medicaid fee-for-service, one in three (33%) accessed dental prevention or treatment services in fiscal year 2000.[16]

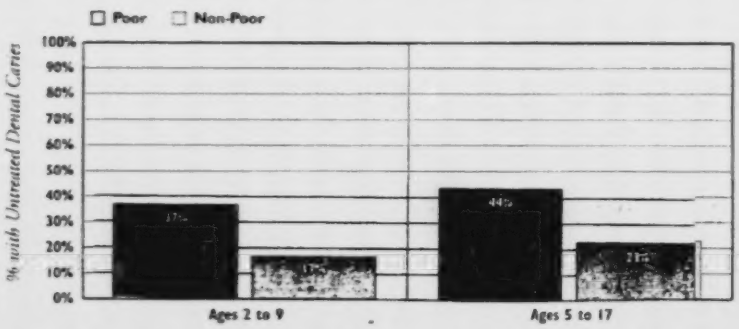
Availability of Dental Services for Rhode Island's Low-Income Children

◇ The federal Medicaid program mandates that states provide comprehensive dental services to eligible children up to age 21, and entitles RIte Care (Rhode Island's Medicaid managed care program) recipients to comprehensive dental prevention and treatment services.[17]

◇ States are required to recruit dentists to provide oral health services through the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, to assure that providers are performing the required services, and to locate and educate eligible families about EPSDT services.[18]

◇ Participation rates of dentists who serve low-income children are very low in Rhode Island. Statewide, there are 113 RIte Care enrollees for each Medicaid dental provider. In the five core cities there are more than 220 RIte Care enrollees per Medicaid dental provider.[19]

Children with Untreated Dental Caries, by Age and Poverty Status, United States



Note: Based on 1996 data from the National Center for Health Statistics. Untreated dental caries was defined as at least one untreated decayed tooth in the primary teeth for ages 2 to 9 and in both primary and permanent teeth for children ages 5 to 17.

Source: *Oral Health In America: A Report of the Surgeon General* (2000). Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

◇ Children in families with incomes below the poverty line and minority children have the greatest extent of untreated dental problems.[20]

◇ The National Institute of Dental Research reports that 80% of tooth decay occurs in only 25% of U.S. children and adolescents, mostly low-income children.[21]

◇ Children eligible for Medicaid services experience twice the ratio of untreated dental disease as more affluent children.[22]

◇ Achieving oral health requires individual actions, including self-care, proper nutrition, and regular dental visits, complemented by an adequate dental care system that is affordable, accessible and includes community education on oral health.[23]

References

[1,2,3,4,20,23] *Oral Health In America: A Report of the Surgeon General* (2000). Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

[2,21] Edelstein, B.L. (May 1998). "Crisis in Care: The Facts Behind Children's Lack of Access to Medicaid Dental Care" *NCEMCH Policy Brief*. Washington, DC: Georgetown University, National Center for Education in Maternal and Child Health.

[3] *Promoting Awareness, Preventing Pain: Facts on Early Childhood Caries* (June 1999). Washington, DC: Georgetown University, National Center for Education in Maternal and Child Health.

[4,13] *Oral Disease: A Crisis Among Children in Poverty* (May 1998). Washington, DC: Georgetown University, National Center for Education in Maternal and Child Health.

[5,10] Lewit, E.M. and Kerrebock, N. (Spring 1998). "Child Indicators: Dental Health" in *The Future of Children*, Vol. 8, No. 1. Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[7] Rhode Island Department of Health, *1999 Survey of Rhode Island Employers on Health Care Coverage*.

[8] Rhode Island Department of Health, Office of Health Statistics, *Rhode Island Health Interview Survey*, 1996.

[11,17] *The Special State Commission to Study and Make Recommendations on Ways to Maintain and Expand Access to Quality Oral Health Care for All Rhode Island Residents*, Senator Elizabeth H. Roberts, Chair (November 2001). Providence, RI: Rhode Island State Senate.

[12] Milbank Memorial Fund, Reforming States Group (1999). *Pediatric Dental Care in CHIP and Medicaid Paying for What Kids Need: Getting Value for State Payments*. New York, NY: Milbank Memorial Fund.

[14] U.S. Department of Health and Human Services (1990). *Healthy People 2000*. Washington, DC: U.S. Government Printing Office.

[15] Office of the Inspector General (1996). *Children's Dental Services Under Medicaid: Access and Utilization*. Washington, DC: U.S. Department of Health and Human Services.

[16] Rhode Island Department of Health and Human Services, January 2001.

[18] Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program, State Medicaid Manual, Part 5, Title XIX of the Social Security Act.

[19] *Study of Alternatives for Delivery of Medicaid Dental Services* (1998). Cranston, RI: Rhode Island Department of Human Services.

BEST COPY AVAILABLE

Children's Mental Health

DEFINITION

Children's mental health is the number of children under age 18 using the mental health treatment system in Rhode Island.

SIGNIFICANCE

Mental health in childhood and adolescence is defined by the U.S. Surgeon General as the achievement of expected developmental cognitive, social and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills. Because childhood is defined by periods of transition, it is important to consider developmental expectations when assessing the mental health of children and adolescents. Only serious deviations from expected cognitive, social and emotional development are considered mental disorders.[1]

One in five U.S. children ages 9 to 17 has a diagnosable mental or addictive disorder. One in ten suffers severe functional impairment as a result of their disorders.[2] Of all the children with some mental or emotional problem or functional limitation it is estimated that only 19% of U.S. children see a mental health provider on a regular basis.[3]

Mental health problems affect children of all backgrounds. Children most at risk for developing a mental disorder or experiencing problems in social-emotional development include those with prenatal damage from exposure to alcohol, illegal drugs, and tobacco; those born with low birth weight, difficult temperament, or an inherited predisposition to a mental disorder; children with external risk factors such as poverty, deprivation, abuse and neglect, family violence, or exposure to traumatic events; and children whose parent has a mental health disorder.[4] Parental substance abuse and maternal depression are common and have significant negative effects on children's social and emotional development.[5]

Children with mental health needs can be found in nearly every system serving children. Primary health care sites, child health care settings, and schools are important sites for the identification of children with mental health needs. Healthy social-emotional development of children can best be addressed by a systems approach in which multiple sectors work collaboratively to meet child and family needs.[6]

Rhode Island Community Mental Health Centers

◆ The Rhode Island Child and Adolescent Service System Program (CASSP) is a state-wide system of care which helps parents and communities plan services for children with emotional, behavioral and/or mental health challenges. CASSP services are carried out through eight Local Coordinating Councils (LCC's) managed by community mental health centers across the state.[7]

◇ The eight Community Mental Health Centers (CMHCs) in Rhode Island are the primary source of public mental health treatment services available in the state. Between December 1, 2000 and November 30, 2001 the community mental health centers provided services to 8,060 Rhode Island children.[8] As of November 30, 2001 there were 4,779 children receiving services, compared to 4,451 at the end of 2000.[9]

◇ Of the 8,060 children receiving service, 23% were being treated for attention deficit disorder and 13% for depressive or mood disorders. More than one in three children (37%) receiving treatment at the community mental health centers was diagnosed with serious mental illness.[10]

◆ More than half (4,591) of the children who received services through community mental health centers in 2001 were between the ages of 12 to 17. Over one-third (2,849) were between the ages of 6 and 11 and 620 were under the age of 6.[11]

◆ One in four (27%) children accessing services through the community mental health centers used RIte Care as their primary payment source, 26% used commercial insurance, and 17% used Medicaid fee-for-service to pay for services. The remainder use a variety of funding sources.[12]

Emotional Development of Young Children

The quality of a child's environment and social interactions in the early years affect brain development, producing lifelong impacts on learning, social skills and mental health.[13,14]

Effective mental health strategies for young children are preventive and designed to:

◇ Enhance the emotional and behavioral well-being of young children to promote early school success, with special attention to children whose emotional development is compromised by poverty or other risk factors.

◇ Help families become more effective nurturers and expand the competencies of non-familial caregivers in child care settings and schools to prevent and address problems.

◇ Ensure that more seriously troubled young children experiencing clearly atypical behavior get appropriate help.[15]

Hospitals

◇ Mental health services are provided through RIte Care as part of the managed care benefit plan. In 1999, 7% of all children enrolled in RIte Care received outpatient mental health services at an average cost of $408 per child. Inpatient hospitalization of children enrolled in RIte Care increased between 1998 and 1999 by both number of admissions and length of stay.[16]

◇ Bradley Hospital is Rhode Island's largest psychiatric center for children. In 2001, there were 1,384 children discharged from Bradley Hospital; 8,463 children participated in its outpatient treatment program; and 12,606 home health visits were provided.[17]

◇ Butler Hospital provides a wide range of psychiatric services for children and adolescents. In 2001, Butler Hospital provided services to 1,179 children and youth age 18 and under. This is a 20% drop from last year. Of these, 852 children were admitted to the hospital. The remaining 327 were in partial hospital or outpatient programs.[18]

Schools

◇ Nationally, the public school system is the sole provider of services for nearly half of all children receiving mental health services.[19] School systems are mandated to provide special education services to children and adolescents whose disabilities interfere with their education.[20]

◇ Schools serve as a primary entrance point to the mental health system. In the 2000-2001 school year, 2,573 Rhode Island children between the ages of 3 and 21 were identified within the special education system as being disabled because of behavioral disorders.[21]

◇ The seven school-based health centers in Rhode Island report high demand for mental health services. At the two high school health centers alone, 839 students received behavioral health services in the 2000-2001 school year. The total number of behavioral health visits for all school-based health centers was 2,047.[22]

References

[13,14] *Mental Health: A Report of the Surgeon General* (1999). Washington, DC: Office of the Surgeon General, U.S. Department of Health and Human Services.

[15] *Mental Health, United States, 2000* (2000). Washington, DC: Office of the Surgeon General, U.S. Department of Health and Human Services.

[13,14] Knitzer, J. (January 2002) *Promoting the Emotional Well-Being of Children and Families: Building Services and Systems to Support the Healthy Emotional Development of Young Children.* New York, NY: National Center for Children in Poverty.

[13] Shonkoff, J. and Phillips, D. eds. (2000). *Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, DC: National Research Council, National Academy Press.

[15] "CASSP System of Care and Regional Programs Fact-sheet" (2000). Rhode Island Department of Children Youth and Families.

[16,17,18] Rhode Island Department of Mental Health Retardation and Hospitals, January 2001.

[16] *Annual Report* (2000). Providence, RI: Rhode Island Governor's Advisory Council on Health.

[17] Bradley Hospital, January 1, 2001 through December 31, 2001.

[18] Butler Hospital, January 1, 2001 through December 31, 2001. Note: totals no longer include Butler satellites located in Lincoln and Warwick, which closed on October 1, 2000.

[19] *School Based Health Centers in Rhode Island* (2000). Providence, RI: Rhode Island Department of Health.

[21] Rhode Island Department of Elementary and Secondary Education, *InfoWorks*, School Year 2000 - 2001.

[22] Rhode Island Department of Health, School Based Health Center Reports, School Year 2000-2001.

Children with Special Needs

DEFINITION

Children with special needs are those who have a chronic disease or disability that requires educational services, health care, and/or related services of a type or amount beyond that required by children generally. Special needs can be physical, developmental, behavioral, and/or emotional. This indicator measures the number of children enrolled in Early Intervention, Special Education, and Supplemental Security Income (SSI) in 2001.

SIGNIFICANCE

As many as one in five children nationwide have a chronic physical, developmental, behavioral or emotional condition that requires health care and related services.[1] Some common chronic and disabling conditions among children include mental retardation, attention deficit disorder, asthma, autism, hearing impairment, communication disorders, seizure disorders, and congenital diseases.[2]

Children with special needs are a heterogeneous group, varying by the type and severity of the chronic disease or disability. Needs will vary based on the age of the child, as well as by the many differences in the population at large - such as family income, race, ethnicity, primary language, and parents' educational level.[3] Children with chronic or disabling conditions are likely to have functional limitations or impairments.[4,5] Youth with special needs are much less likely than their non-disabled peers to finish high school, go on to postsecondary education, find employment, and live independently.[6]

There are some issues of common concern to families of children with chronic or disabling conditions.[7,8] Whether disabilities are mild or severe, they have the potential to create special needs related to physical health, mental health, education, parent support, child care, recreation, and career preparation.[9,10,11] For many parents, having a child with special needs has a significant impact on their finances, their jobs, and their family life.[12]

Children with special needs require access to health care that is appropriate to their individualized health, education, and social-emotional needs. Some children with disabilities may require costly therapeutic and health care services, wheelchairs, assistive technology, or home modifications. Because many services are not fully-covered by insurance, families from all income levels can incur serious financial burdens.[13]

SSI and Medical Assistance

◇ Children who meet certain disability criteria are eligible for Medicaid and/or cash assistance through the federal Supplemental Security Income (SSI) program.[15] As of December 1, 2001, there were 2,804 Rhode Island children receiving Medical Assistance benefits because of their enrollment in SSI.[16] One national study indicates that 85% of the children with special needs enrolled in Medicaid are not eligible for SSI.[17]

◇ In Rhode Island, the Katie Beckett eligibility provision provides Medical Assistance coverage to certain children under the age of 18 who have serious disabling conditions and live at home. Katie Beckett enables children with disabilities to be cared for at home instead of in an institution. As of October 2001, there were 911 Rhode Island children enrolled in Medical Assistance through the Katie Beckett eligibility.[18]

◇ Rhode Island has established CEDARR Family Centers to provide comprehensive evaluation, diagnosis, assessment, referral and re-evaluation services to families of children with special health care needs. Two centers began providing services in 2001.[19]

Children in the Child Welfare System

◇ According to the National Survey of American Families, 27% of children in the child welfare system across the U.S. show high levels of behavioral and emotional problems and 28% have a physical, learning, or mental health condition that limits their activities.[20]

◇ More than half of young children in foster care experience serious physical problems and over half experience developmental delays. This is four to five times the rate of developmental delay found among children in the general population.[21]

Children Enrolled in Early Intervention, Ages Birth to 3

◇ States are required to provide appropriate Early Intervention services to all children from birth to age 3 who are developmentally delayed or have been diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay.

◇ In 2001, the seven Early Intervention programs in Rhode Island served 2,120 children ages birth to three who were developmentally delayed or at risk. This is 6% of all Rhode Island children up to age 3.

◇ Three in five (62%) children enrolled in Early Intervention in 2001 had significant developmental delays, i.e. physical, cognitive, behavioral, and/or emotional delays of unknown medical origin. One in five (21%) had a single established condition affecting development, such as Down Syndrome or cerebral palsy.

◇ One in ten children (9%) had multiple established conditions, i.e. evidence of developmental delay in combination with multiple prenatal or early life biological events that put the child at risk of further developmental delays. Risk criteria include teen parents, impoverished home environment, poor nutrition, and others.

Source: Rhode Island Department of Health, January 2002

Children Enrolled in Special Education, Ages 3 to 21

◆ Local school systems are responsible for identifying and evaluating students ages 3 to 21 whom they have reason to believe are students with disabilities and therefore might require special education and related services.

◆ In Rhode Island in 2000-2001, there were 32,043 public school children enrolled in Special Education. 21% of the public school student population. One-quarter of children receiving special education services have health impairments (9%), behavioral disorders (8%), mental retardation (4%), or developmental delays (3%).

◆ Early Intervention programs for children birth to age 3 are required to provide transition services for children who may be eligible for Special Education at age 3. During the 2000-2001 school year, there were 2,649 children ages 3 to 5 receiving Special Education services in Rhode Island public schools.

Source: The Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 2001.

References

[1] "Access to a Medical Home" (July 2001). Rockville, MD: Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

[2,7] Terman, D.L., Larner, M.B., Stevenson, C.S., Behrman, R.E. "Special Education for Students with Disabilities" in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[3] Rhode Island Department of Health, Disability and Health Program, 1998.

[4] Msall, M. et. al. "Functional Disability and School Activity Limitations in 41,300 School-Age Children: Relationship to Medical Impairments" [Manuscript]. (January 2002). Providence, Rhode Island: Brown University Department of Pediatric Research.

[5] "Healthy and Ready to Work" (July 2001). Rockville, MD: Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

[6,8,9,12,13] Wells, N. et al (2000). *What Do Families Say About Health Care for Children with Special Health Care Needs? Your Voice Counts!* Boston, MA: Family Voices at the Federation for Children with Special Health Care Needs.

[8] Martin, E.W., Martin, R. and Terman, D.L. "The Legislative and Litigation History of Special Education" in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[11] Griffin, J. (June 1998). *Health Care Needs of Children with Disabilities on Medicaid: Results of a Caregivers Survey.* Cranston, RI: RI Department of Human Services, Center for Child and Family Health and RI Department of Health, Disability and Health Program.

[14] Social Security: Supplemental Security Income (July 1998, Informational Brochure). Washington, DC: Social Security Administration.

[15] Rhode Island Department of Human Services, Center for Child and Family Health (December 2001).

[17] Allen, S.M. and A.L. Cooke (October 2000). *The Facts of Medicaid: The Complexities of Caring for People with Chronic Illnesses and Disabilities.* Princeton, NJ: Center for Health Care Strategies, Inc.

[18] Rhode Island Department of Human Services, 2001.

[19] Kortenkamp, K. and J. Ehrle. *The Well-Being of Children Involved with the Child Welfare System: A National Overview* (February 2002). Washington, DC: The Urban Institute.

[20] Dicker, S. et. al. *Improving the Odds for the Healthy Development of Children in Foster Care* (2001). New York, NY: National Center for Children in Poverty.

Women and Children Receiving WIC

DEFINITION

Women and children receiving WIC is the percentage of eligible women, infants and children served by the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

SIGNIFICANCE

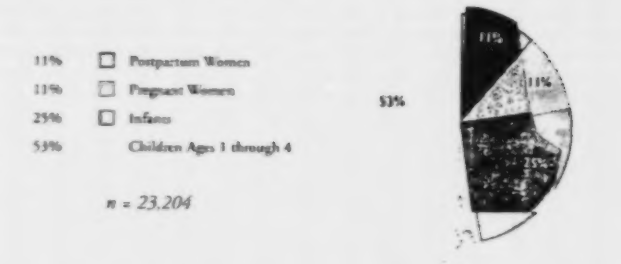
The Special Supplemental Nutrition Program for Women, Infants and Children is a preventive program providing nutritious food, nutrition education, and improved access to health care.[1] This federally-funded program serves pregnant, postpartum and breastfeeding women, infants, and children less than five years of age. Household income must be below 185% of the poverty level. In addition, any individual who participates in the Food Stamp program, RIte Care, Medicaid, cash assistance through the Family Independence Program, or is a member of a family in which a pregnant woman or infant receives Medicaid benefits, is deemed automatically income eligible. Participants must have a specified health or nutritional risk, such as abnormal weight gain during pregnancy or iron deficiency anemia.[2,3] WIC is not an entitlement program and is not funded at a level that is sufficient to serve all eligible women, infants, and children.[4]

All WIC participants receive vouchers for foods such as eggs, cereal, milk, cheese, infant formula, juice, carrots, and high protein foods (beans, peanut butter, tuna fish) that can be redeemed at retail stores.[5] The WIC Farmer's Market Nutrition Program improves the intake of fresh fruits and vegetables by providing coupons to WIC participants to help them to purchase fresh produce at local farmers' markets. In Rhode Island in 2001, 13 farmers markets provided fresh fruits and vegetables to more than 14,345 recipients.[6]

WIC promotes breastfeeding as the optimal method of infant feeding. Program eligibility for breastfeeding mothers is extended for up to one year.[7] In the last 3 months of 2001, 14% of infants participating in the WIC program in Rhode Island were being breastfed.[8]

WIC has been shown to reduce premature births and protect infants and children from low-birth weight, iron-deficiency anemia, failure to thrive and other nutrition-related health problems.[9,10,11,12] By protecting a child's cognitive development, WIC results in savings for special education that may have otherwise been incurred due to malnutrition in infancy and early childhood.[13] Mothers and children who are poor, minority or poorly educated benefit most.[14]

Women, Infants, and Children Served by WIC, Rhode Island, December 2001



Source: Rhode Island Department of Health, Division of Family Health, WIC Program, December 2001.

WIC Improves Access to Health Care

◇ The WIC program is closely connected to the health care delivery system. Participation in WIC increases the likelihood that women will receive early, regular prenatal care and that their children will receive regular pediatric care and immunizations.[15,16]

◇ As of December 2001, 71% of eligible women, infants and children were served across the state.[17] Three of the five cities with the highest child poverty rates — Providence, Pawtucket, and Central Falls — have WIC participation rates that exceed the statewide average of 71%. In Newport, only 49% of women, infants, and children eligible for WIC were served, while Woonsocket served 70%.[18]

BEST COPY AVAILABLE

Table 11. **Women, Infants and Children Receiving WIC, Rhode Island, December 2001**

CITY/TOWN	ESTIMATED* NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	211	34	16%
Bristol	403	202	50
Burrillville	427	238	56%
Central Falls	1,642	1,508	92%
Charlestown	105	101	96%
Coventry	592	310	52%
Cranston	1,753	883	50%
Cumberland	554	270	49%
East Greenwich	241	58	24%
East Providence	1,205	756	63%
Exeter	13	37	*100%
Foster	10	56	*100%
Glocester	293	32	11%
Hopkinton	33	103	*100%
Jamestown	96	14	15%
Johnston	598	304	51%
Lincoln	360	143	40%
Little Compton	63	6	10%
Middletown	694	235	34%
Narragansett	71	82	*100%
Newport	1,332	653	49%
New Shoreham	39	1	3%
North Kingstown	370	236	64%
North Providence	262	349	*100%
North Smithfield	59	33	56%
Pawtucket	3,198	2,752	86%
Portsmouth	249	108	43%
Providence	11,280	9,191	82%
Richmond	24	78	*100%
Scituate	75	71	95%
Smithfield	174	98	56%
South Kingstown	402	238	59%
Tiverton	260	100	39%
Warren	156	130	83%
Warwick	1,613	930	58%
Westerly	648	353	54%
West Greenwich	38	17	45%
West Warwick	777	690	89%
Woonsocket	2,566	1,804	70%
Core Cities	*20,018*	*15,908*	*79%*
Remainder of State	*12,868*	*7,296*	*57%*
Rhode Island	*32,886*	*23,204*	*71%*

**Estimates are based on 1990 Census, and do not reflect recent increases in eligible population.*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, WIC Program, December 2001.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of children under age 5 who live in families with an income less than 185% of poverty, according to the 1990 Census of Population. This is an estimate of the eligible population and does not take into account any increases or decreases in the number of women and children who became income eligible between 1990 and 2001.

References for Indicator

[1,2,3] Devaney, B.L., et al. (1997). Programs that Mitigate the Effects of Poverty on Children in *The Future of Children: Children and Poverty, Vol. 7, No. 2* (Summer/Fall 1997). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[2] Food Research and Action Center (2000). *Federal Food Programs: Special Supplemental Nutrition Program for Women, Infants, and Children.* Washington, D.C.: Food Research and Action Center.

[4] *WIC at a Glance (Fact Sheet)* (August 2001). Washington, DC: United States Department of Agriculture.

[5] Food Research and Action Center (1999). *WIC in the States: Twenty-Five Years of Building a Healthier America.* Washington, D.C.: Food Research and Action Center.

[6,7,8] Rhode Island Department of Health, Division of Family Health, WIC Program, December 2001.

[9,10] *How WIC Helps* (August 2001). Washington, DC: United States Department of Agriculture.

[11] Kowaleweski-Jones, L., et al. (2001). *The Effects of WIC on Children's Health and Development: Evidence From NLSY Children.* Discussion Paper No. 1207-00. Madison, WI: Institute for Research on Poverty.

[12] Mackey-Bilaver, L., et al. (January 2000). *The Patterns of Food Stamp and WIC Participation and Their Effects on Health of Low-Income Children.* JCPR Working Paper 129. Chicago, IL: Joint Center for Research on Poverty.

[13] *Statement on the Link Between Nutrition and Cognitive Development in Children* (1998). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[14,15] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

Breastfeeding

DEFINITION

Breastfeeding is the percentage of newborn infants who are exclusively breastfed at the time of hospital discharge.

SIGNIFICANCE

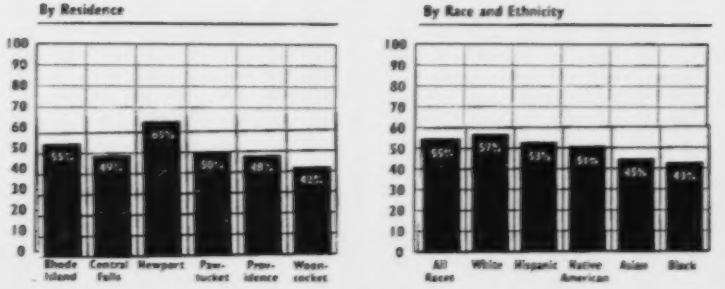
The American Academy of Pediatrics (AAP) identifies breastfeeding as the ideal method of feeding and nurturing infants and recognizes breastfeeding as a primary factor in achieving optimal infant and child health, growth and development. The AAP recommends exclusive breastfeeding for approximately 6 months after birth and, in conjunction with appropriate solid foods, for at least 12 months after birth and thereafter as long as mutually desired.[1] Healthy People 2010 has established target breastfeeding rates of 75% at birth, 50% at 6 months and 25% at one year.[2]

Breastfeeding provides optimal nutrition for the newborn and decreases the incidence of diarrhea, lower respiratory infections and ear infections. Breastfeeding has been linked to decreases in Sudden Infant Death Syndrome, diabetes, allergies, asthma, lymphoma and other illnesses; improved cognitive development and school performance in children; a reduced incidence of child abuse; and improved maternal health, including reduced rates of breast and ovarian cancer.[3,4,5] Breastfeeding provides significant social and economic benefits including reduced cost to the family, reduced health care costs and reduced employee absenteeism.[6]

Nationally, the highest rates of breastfeeding, as measured by initiation in the hospital, occur among women who are White or Hispanic, older (over 30), higher-income and college-educated. The lowest rates occur among women who are Black, less than 20 years old, have low educational attainment, work full-time and/or participate in the WIC program.[7]

Breastfeeding can be effectively promoted by health professionals through culturally-appropriate parent education, physician support, hospital policies that promote early and exclusive breastfeeding, timely postpartum follow-up care and home health visits, and links to lactation support networks and resources.[8,9,10,11] In Rhode Island the WIC program provides participants with breastfeeding support and assistance from trained peer counselors.

Breastfeeding Rates in Rhode Island, 1996-2000



◇ Between 1996 and 2000, the breastfeeding rate in Rhode Island was 55%. Six months after hospital discharge only 29% of infants were still being breastfed. Breastfeeding rates in Rhode Island as in the nation as a whole vary significantly by race, ethnicity and socioeconomic status.[12,13]

Source: Rhode Island Department of Health, Newborn Developmental Risk Assessment Screening. Breastfeeding rates for 60,751 women who gave birth between 1996 and 2000.

Public and Workplace Policies that Promote Breastfeeding

◇ African American women in the United States and in Rhode Island have the lowest breastfeeding rates. They are also more likely than other women to return to work earlier (at 8 weeks after birth) and to be engaged in jobs that make continued success in breastfeeding more difficult.[14]

◇ Public policies and employer policies that promote breastfeeding are important for working women to succeed in breastfeeding. Paid maternity leave, on-site child care, opportunities during the day to nurse or express milk in a private setting, financial assistance with the rental or purchase of a breast pump, flexible work hours, job sharing and other family friendly policies can assist women who return to work to continue breastfeeding.[15,16,17] Rhode Island is one of five states that provides Temporary Disability Insurance payments for women who give birth.[18]

Table 12

Breastfeeding Rates, Rhode Island, 1996-2000

CITY/TOWN	NUMBER OF BIRTHS	BREASTFEEDING	PERCENT BREASTFEEDING
Barrington	788	635	81%
Bristol	1,058	648	61%
Burrillville	757	409	54%
Central Falls	1,664	821	49%
Charlestown	491	332	68%
Coventry	1,907	1,057	55%
Cranston	3,786	1,970	52%
Cumberland	1,570	969	62%
East Greenwich	767	552	72%
East Providence	2,480	1,268	51%
Exeter	318	211	66%
Foster	220	149	68%
Glocester	388	230	59%
Hopkinton	725	469	65%
Jamestown	181	150	83%
Johnston	1,484	680	46%
Lincoln	870	545	63%
Little Compton	115	98	85%
Middletown	1,068	770	72%
Narragansett	609	400	66%
Newport	1,675	1,089	65%
New Shoreham	54	41	76%
North Kingstown	1,598	1,160	73%
North Providence	2,130	1,076	51%
North Smithfield	615	354	58%
Pawtucket	4,842	2,408	50%
Portsmouth	874	654	75%
Providence	13,281	6,362	48%
Richmond	168	109	65%
Scituate	591	399	68%
Smithfield	772	504	65%
South Kingstown	1,416	999	71%
Tiverton	348	238	68%
Warren	553	297	54%
Warwick	4,304	2,304	54%
Westerly	1,169	699	60%
West Greenwich	299	216	72%
West Warwick	1,978	903	46%
Woonsocket	2,621	1,100	42%
Unknown	*217*	*33*	*N/A*
Core Cities	*24,083*	*11,780*	*49%*
Rest of Rhode Island	*36,668*	*21,520*	*59%*
Rhode Island	*60,751*	*33,300*	*55%*

Sources

Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program Database. Breastfeeding rates for 60,751 infants born in Rhode Island hospitals between 1996 and 2000. Breastfeeding is defined as breastfeeding exclusively at the time of hospital discharge. Births to Rhode Island women that occurred outside Rhode Island are not included.

References for Indicator

[1] [2] [3] "Breastfeeding and the Use of Human Milk – Policy Statement" (December 1997) in *Pediatrics*, Vol. 100, No.6, Elk Grove, IL: American Academy of Pediatrics.

[4] [5] [6] *HHS Blueprint for Action on Breastfeeding* (2000). Washington, DC: U.S. Department of Health and Human Services.

[7] Wright, N. (Spring/Summer 2000). "Breastfeeding and Early Childhood Development: Strategies for Proposition 10 Implementation" in *Breastfeeding Best for Baby and Mother* (Newsletter), Vol. 2, Issue 1. Elk Grove, IL: Division of Community and Health Services, American Academy of Pediatrics.

[8] *Mothers Survey Breastfeeding Trends Through 1999* (2000). Ross Products Division, Abbott Laboratories.

[9] *Ten Steps to Support Parents' Choice to Breastfeed Their Baby* (1999). Elk Grove, IL: American Academy of Pediatrics.

[10] Rhode Island Department of Health, Newborn Developmental Risk Assessment Screening, 1996-2000.

[11] *Breastfeeding: Foundation for a Healthy Future* (2000). New York, NY: UNICEF.

[12] *Advancing Women's Health: Health Plans' Innovative Programs to Breastfeeding Promotion* (July 2001). Washington, DC: U.S. Department of Health and Human Services and American Association of Health Plans.

[13] Idemoto, S. (2000). *Family Leave Insurance: A Proposal for Washington Workers*. Seattle, WA: Economic Opportunity Institute.

Women with Delayed Prenatal Care

DEFINITION

Women with delayed prenatal care is the percentage of women beginning prenatal care in the second or third trimester of pregnancy or receiving no prenatal care at all. Data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

Timely and comprehensive prenatal care increases the likelihood of delivering a healthy infant of normal birthweight, results in fewer complications at birth, and reduces health care costs. Women receiving late or no prenatal care are at increased risk of having infants who are low birthweight, who are stillborn, or who die within the first year of life.[1]

Prenatal care offers the opportunity to screen for and treat conditions that increase the risk for poor birth outcomes. Effective prenatal care also screens for and intervenes with conditions including smoking, substance use, physical abuse, nutritional deficiencies, and needs for food, clothing and shelter.[2] Women who receive adequate prenatal care are more likely to obtain preventive health care for their children, such as scheduling well-baby visits, immunizations, and regular health checkups.[3]

Early prenatal care is especially important for women who face multiple risks for poor birth outcomes, including poverty and low maternal education.[4] Several studies indicate that low-income women who receive enhanced prenatal care services experience improved birth outcomes. Enhanced prenatal care services may include outreach, case management, risk assessment, smoking cessation, nutritional and psychosocial counseling, health education, guidance on infant and child development, referrals to WIC and other social services, and home visits.[5]

Late or No Prenatal Care

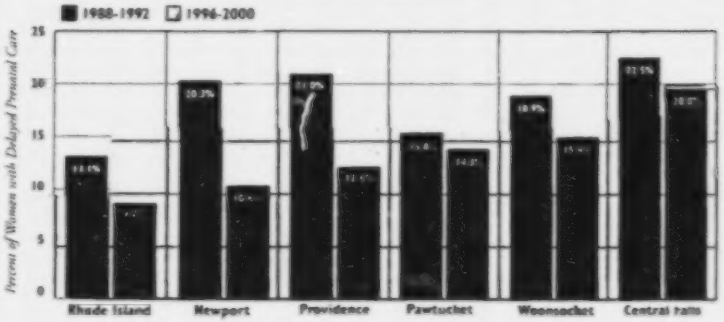
	1990	2000
RI	2.0%	1.4%
US	6.1%	3.8%
State Rank		*1st*

1st is best; 50th is worst

Late prenatal care is defined as beginning prenatal care in the third trimester.

Source: *The Right Start for America's Newborns, A Decade of City and State Trends: 1990-1999* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Delayed Prenatal Care, Rhode Island and Core Cities, 1988-1992 and 1996-2000



◇ Over the past decade, the rate of delayed prenatal care has dropped by nearly half for the state as a whole and in the core cities of Providence and Newport.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1988-1992 average and 1996-2000 average. Data for 1997-2000 are provisional. Delayed prenatal care is defined as beginning care in the second trimester or later.

Adequate Prenatal Care

◇ In order to improve health outcomes for infants, prenatal care must be regular as well as early. The Adequacy of Prenatal Care Utilization Index considers when prenatal care begins, how many visits occur and the infant's gestational age. The Adequacy Index classifies prenatal care into four categories: inadequate, intermediate, adequate and adequate-plus.[6]

◇ From 1996-1998, Rhode Island ranked fourth best in the country for adequacy of prenatal care. Approximately 84% of Rhode Island mothers received adequate or adequate-plus care, compared to 74% for the United States as a whole.[7]

◇ During 1996-1998, White mothers in Rhode Island were much more likely to receive adequate prenatal care than mothers from other racial/ethnic groups: 86% of White mothers received adequate care compared to 78% of Black mothers and 77% of Hispanic mothers.[8]

BEST COPY AVAILABLE

Table 13. **Delayed Prenatal Care, Rhode Island, 1996-2000**

CITY/TOWN	# BIRTHS	# DELAYED CARE	% DELAYED CARE
Barrington	814	20	2.5%
Bristol	1,121	92	8.2%
Burrillville	787	57	7.2%
Central Falls	1,695	339	20.0%
Charlestown	434	29	NA
Coventry	1,950	118	6.1%
Cranston	4,148	253	6.1%
Cumberland	1,652	92	5.6%
East Greenwich	582	24	4.1%
East Providence	2,539	209	8.2%
Exeter	352	18	NA
Foster	200	12	NA
Glocester	478	34	NA
Hopkinton	467	56	NA
Jamestown	198	4	NA
Johnston	1,526	93	6.1%
Lincoln	976	53	5.4%
Little Compton	161	15	NA
Middletown	1,106	54	4.9%
Narragansett	694	25	3.6%
Newport	1,629	176	10.8%
New Shoreham	62	10	NA
North Kingstown	1,510	62	4.1%
North Providence	1,600	94	5.9%
North Smithfield	529	28	5.3%
Pawtucket	5,014	715	14.3%
Portsmouth	940	32	3.4%
Providence	13,460	1,697	12.6%
Richmond	473	26	NA
Scituate	509	24	4.7%
Smithfield	850	33	3.9%
South Kingstown	1,325	56	4.2%
Tiverton	647	52	8.0%
Warren	586	53	9.0%
Warwick	4,500	228	5.1%
Westerly	1,369	201	14.7%
West Greenwich	302	10	NA
West Warwick	2,022	179	8.9%
Woonsocket	2,911	448	15.4%
Core Cities	*24,709*	*3,375*	*13.7%*
Remainder of State	*37,417*	*2,348*	*6.3%*
Rhode Island	*62,126*	*5,723*	*9.2%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1996-2000. Data for 1997-2000 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1996-2000.

References for Indicator

[1] *Trends in the Well-Being of America's Children and Youth 2000* (2000). Washington, DC: U.S. Department of Health and Human Services.

[2] Alexander, G.R. and Korenbrot, C.C. (1995). "The Role of Prenatal Care in Preventing Low Birth Weight," in *The Future of Children: Low Birth Weight*, Vol. 5, No. 1. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[3] "New Data Show Prenatal, Postdelivery Progress" in *CDF Reports* (October 1998). Washington, DC: Children's Defense Fund.

[4] *America's Children: Key National Indicators of Well-Being 2001* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[5] *Maternal and Child Health Principles in Practice: An Analysis of Select Provisions in Medicaid Managed Care Contracts* (1998). Washington, DC: Association of Maternal and Child Health Programs and George Washington University Medical Center, Center for Health Policy Research.

[6] *Maternal, Infant, and Child Health in the United States* (2001). Washington, DC: March of Dimes.

[7] March of Dimes Web site: http://peristats.modimes.org/printState.cfm (December 2001).

Low Birthweight Infants

DEFINITION

Low birthweight infants is the percentage of infants born weighing under 2,500 grams (5.5 pounds). The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

A baby's birthweight is a key indicator of newborn health and is directly related to infant survival and healthy development. Infants born weighing less than 5.5 pounds are at greater risk for physical and developmental problems than infants of normal weight.[1] Babies are born with low birthweight for a number of reasons: some are born prematurely and others are born full-term but are small for their gestational age.[2]

Low birthweight babies are at higher risk of death or long-term illness and disability than infants of normal birthweight.[3] Low birthweight babies are 20 times more likely than babies of normal weight to die within the first year of life.[4] Low birthweight infants who survive are at greater risk for physical and developmental problems. Children from 6 to 15 years old who were born low birthweight are 50% more likely than children of normal birthweight to be enrolled in a special education program.[5]

Increased risk of low birthweight is strongly associated with poverty, maternal smoking and low levels of educational attainment.[6] Prevention of low birthweight focuses on early and comprehensive prenatal care, adequate nutrition and weight gain, and smoking cessation. Smoking during pregnancy has been linked to 20% to 30% of low birthweight infants and to negative long-term effects including physical, mental, and cognitive impairments.[7]

Black women are much more likely to have a low birthweight infant than women of any other racial or ethnic group.[8] The low birthweight rate for Black infants in Rhode Island is nearly twice that for White infants.[9] Underlying the higher rate of low birthweight among Blacks in the U.S. is the higher rate of preterm delivery (babies born before 37 weeks gestation).[10]

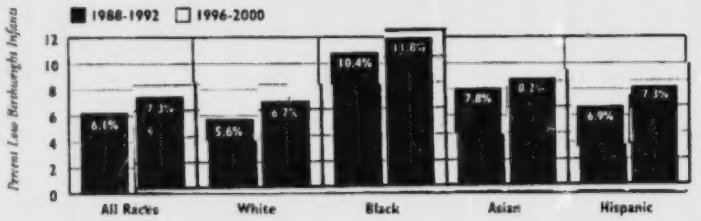
Low Birthweight Infants

	1990	1999
RI	6.2%	7.3%
US	7.0%	7.6%
State Rank		*20th*

1st is best; 50th is worst

Source: *The Right Start for America's Newborn: A Decade of City and State Trends 1990-1999* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Low Birthweight Infants, by Race/Ethnicity, Rhode Island, 1988-1992 and 1996-2000



◇ Over the past decade, the percentage of infants born low birthweight has increased in all racial and ethnic groups.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database. 1988-1992 average and 1996-2000 average. Data for 1997-2000 are provisional.

Increase in Multiple Births and Low Birthweight Infants

◇ Nationally, the percentage of low birthweight infants has steadily increased since 1984. The national rate was 7.6 in 1998, the highest since the early 1970's.[13] In 1999, Rhode Island ranked 20th best in the nation with 7.3% of infants born low birthweight.[14]

◇ One reason for the increase in low birthweight infants is the growing numbers of twin, triplet and other multiple births. Twins and other multiple births are more likely to be low birthweight than singleton births.[15] In Rhode Island between 1996 and 2000, 6% of singletons were born low birthweight, compared to 52% of twin births and 95% of triplets and higher-order multiple births.[16]

◇ In the U.S. in 1997, approximately 80% of triplet and higher-order multiple births were attributable to fertility drugs and/or reproductive technologies.[17]

Table 14. **Low Birthweight Infants, Rhode Island, 1996-2000**

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	814	42	5.2%
Bristol	1,121	80	7.1%
Burrillville	787	55	7.0%
Central Falls	1,695	141	8.3%
Charlestown	434	26	NA
Coventry	1,950	122	6.3%
Cranston	4,148	295	7.1%
Cumberland	1,652	110	6.7%
East Greenwich	582	36	6.2%
East Providence	2,539	168	6.6%
Exeter	352	12	NA
Foster	200	12	NA
Glocester	478	28	NA
Hopkinton	467	38	NA
Jamestown	198	15	NA
Johnston	1,526	111	7.3%
Lincoln	976	59	6.0%
Little Compton	161	8	NA
Middletown	1,106	44	4.0%
Narragansett	694	52	7.5%
Newport	1,629	86	5.3%
New Shoreham	62	23	NA
North Kingstown	1,510	75	5.0%
North Providence	1,600	141	8.8%
North Smithfield	529	42	7.9%
Pawtucket	5,014	387	7.7%
Portsmouth	940	53	5.6%
Providence	13,460	1,201	8.9%
Richmond	473	26	NA
Scituate	509	34	6.7%
Smithfield	850	41	4.8%
South Kingstown	1,325	76	5.7%
Tiverton	647	32	4.9%
Warren	586	46	7.8%
Warwick	4,500	313	7.0%
Westerly	1,369	76	5.6%
West Greenwich	302	12	NA
West Warwick	2,022	161	8.0%
Woonsocket	2,911	238	8.2%
Core Cities	*24,590*	*2,053*	*8.3%*
Remainder of State	*37,129*	*2,464*	*6.6%*
Rhode Island	*62,126*	*4,517*	*7.3%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1996-2000. Data for 1997-2000 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1996-2000.

References for Indicator

[1,2] "Infant Health Improving" in *CDF Reports*, Vol. 17, No. 12 (November 1996). Washington, DC: Children's Defense Fund.

[3,4,5,6,7,8] *America's Children: Key National Indicators of Well-Being 2001* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[4] Lewit, E., et al. (1995). The Direct Cost of Low Birth Weight in *The Future of Children: Low Birthweight, Vol. 5, No. 1* (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[5] *Child Health USA 2001* (2001). Rockville, MD: U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

[7] Chomitz, V.R., Cheung, L.W.Y., and Lieberman, E., "The Role of Lifestyle in Preventing Low Birth Weight" in *The Future of Children: Low Birthweight, Vol. 5, No. 1* (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[8] Paneth, N.S. (1995). "The Problem of Low Birthweight" in *The Future of Children: Low Birthweight, Vol. 5, No. 1* (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[9,10] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1996-2000. Data for 1997-2000 are provisional.

[9] *KIDS COUNT Data Book: State Profiles of Child Well-Being* (2001). Baltimore, MD: The Annie E. Casey Foundation.

[10] "Contribution of Assisted Reproductive Technology and Ovulation – Inducing Drugs to Triplet and Higher-Order Multiple Births – United States, 1980-1997", *MMWR Weekly* Vol. 49, No.24 (June 23, 2000). Bethesda, MD: Centers for Disease Control and Prevention.

Infant Mortality

DEFINITION

Infant mortality is the number of deaths occurring to infants under one year of age per 1,000 live births. The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

The infant mortality rate is an important measure of the well-being of infants, children, and pregnant women. Infant mortality is associated with a variety of factors, including women's health status, quality and access to medical care, socioeconomic conditions, and public health practices.[1] In the United States in 1998, more than one-third of infant deaths were caused by birth defects, preterm delivery, and low birthweight. Other leading causes of infant mortality include Sudden Infant Death Syndrome (SIDS), maternal complications, and Respiratory Distress Syndrome.[2] About a third of infant deaths occur after the first month of life. These deaths are associated with conditions or events that arise after the delivery and may be influenced by social or environmental factors such as maternal smoking or access to health care.[3,4]

Communities with multiple problems such as poverty, poor housing conditions, and unemployment tend to have higher infant mortality rates than more advantaged communities.[5] Risk factors contributing to infant deaths include a lack of prenatal care and preventive care, short intervals between pregnancies, inadequate maternal nutrition, poor living conditions, and a mother who has received less than 12 years of education.[6,7]

Infant mortality has two components: neonatal mortality, deaths of infants younger than 28 days, and postneonatal mortality, deaths between 28 days and one year old.[8] From 1996 to 2000, 388 infants died before their first birthday in Rhode Island. Of these, 75% were younger than 28 days old.[9]

Infant Mortality Rate
(rate per 1,000 live births)

	1990	1998
RI	8.1	7.0
US	9.2	7.2
State Rank		*16th*

1st is best; 50th is worst

Source: *Kids Count Data Book: State Profiles of Child Well-Being 2001* (2001). Baltimore, MD: The Annie E. Casey Foundation.

Delayed Prenatal Care, Low Birthweight and Infant Mortality, Core Cities and Rhode Island, 1996-2000

	Delayed Prenatal Care	Low Birthweight Infants	Infant Deaths (per 1,000 live births)
Providence	12.6%	8.9%	9.8
Pawtucket	14.3%	7.7%	8.4
Central Falls	20.0%	8.3%	7.7
Woonsocket	15.4%	8.2%	4.8
Newport	10.8%	5.3%	4.9
Core Cities	13.7%	8.3%	8.4
Rhode Island	9.2%	6.6%	6.2

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1996-2000 average. Data for 1997-2000 are provisional. Delayed prenatal care is the percentage of women beginning prenatal care in the second or third trimester of pregnancy or receiving no prenatal care at all. Low birthweight infants is the percentage of infants born weighing less than 2,500 grams (5.5 pounds).

Infant Mortality Rates Steadily Improve But Disparities Still Exist

◇ Improved access to prenatal care in the first trimester has contributed to a decrease in the infant mortality rates across the United States and in Rhode Island.[10] Rhode Island's core cities, those with greater than 15% child poverty, had an average infant mortality rate of 8.4, ranging from a high of 9.8 in Providence to a low of 4.8 and 4.9 in Woonsocket and Newport.[11]

◇ There are continuing racial and ethnic disparities in timely receipt of prenatal care. In Rhode Island between 1996 and 2000, 8.3% of White women obtained delayed prenatal care compared to 16.0% of Black women, 15.5 % of Asian women and 13.7% of Hispanic women.[12]

◇ Low birthweight is one of the top three causes of infant mortality. Babies born preterm and low birthweight have a high probability of experiencing developmental problems, suffering from illnesses and dying within the first year of life.[13]

Table 15.

Number of Infant Deaths, Rhode Island, 1996-2000

CITY/TOWN	# BIRTHS	# INFANT DEATHS	RATE/1000 BIRTHS
Barrington	814	1	1.2
Bristol	1,121	5	4.5
Burrillville	787	4	5.1
Central Falls	1,695	13	7.7
Charlestown	434	1	NA
Coventry	1,950	4	2.1
Cranston	4,148	20	4.8
Cumberland	1,652	11	6.7
East Greenwich	582	3	5.2
East Providence	2,539	14	5.5
Exeter	352	1	NA
Foster	200	2	NA
Glocester	478	3	NA
Hopkinton	467	3	NA
Jamestown	198	0	NA
Johnston	1,526	9	5.9
Lincoln	976	6	6.1
Little Compton	161	1	NA
Middletown	1,106	6	5.4
Narragansett	694	2	2.9
Newport	1,629	8	4.9
New Shoreham	62	1	NA
North Kingstown	1,510	3	2.0
North Providence	1,600	16	10.0
North Smithfield	529	1	1.9
Pawtucket	5,014	42	8.4
Portsmouth	940	4	4.3
Providence	13,460	132	9.8
Richmond	473	1	NA
Scituate	509	1	2.0
Smithfield	850	1	1.2
South Kingstown	1,325	5	3.8
Tiverton	647	2	3.1
Warren	586	3	5.1
Warwick	4,500	28	6.2
Westerly	1,369	4	2.9
West Greenwich	302	0	NA
West Warwick	2,022	13	6.4
Woonsocket	2,911	14	4.8
Core Cities	*24,709*	*208*	*8.4*
Remainder of State	*37,417*	*194*	*5.2*
Rhode Island	*62,126*	*388*	*6.2*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1996-2000. Data for 1997-2000 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

NA: Rates were not calculated for cities and towns with less than 500 births, as rates for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1996-2000.

References for Indicator

[1,6] *America's Children: Key National Indicators of Well-Being 2001* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2,4] *Maternal, Infant, and Child Health in the United States* (2001). Washington, DC: March of Dimes.

[3] Paneth, N.S. (1995). "The Problem of Low Birth Weight" in *The Future of Children: Low Birth Weight, Vol 5, No.1* (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[5] *KIDS COUNT Data Book: State Profiles of Child Well-Being 2001* (2001) Baltimore, MD: The Annie E. Casey Foundation.

[7,8,9,10] *The Right Start State Trends: Condition of Babies and Their Families Across the Nation* (2001). Baltimore, MD: The Annie E. Casey Foundation.

[8] *Child Health USA 2001* (2001). Rockville, MD: Department of Health and Human Services, Maternal and Child Health Bureau.

[9,11,12] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1996-2000. Data for 1997-2000 are provisional.

[10] "New Data Show Prenatal, Postdelivery Progress" in *CDF Reports* (1998). Washington, DC: Children's Defense Fund.

Children with Lead Poisoning

DEFINITION

Children with lead poisoning is the percentage of three-year-old children screened for lead poisoning who had elevated blood levels (≥10ug/dL) at any time prior to December 31, 2001. These data are for children eligible to enter kindergarten in the Fall of 2003 (i.e., born between September 1, 1997 and August 31, 1998).

SIGNIFICANCE

Childhood lead poisoning is one of the most common pediatric health problems, yet it is entirely preventable. Infants, toddlers and preschool age children are most susceptible to the toxic effects of lead and absorb lead more readily than adults.[1] Lead's effects on the developing central nervous system may be irreversible.[2] Learning disabilities, hyperactivity, antisocial behavior, attention deficit disorder, stunted growth, hearing and speech impediments and loss of intelligence can be attributed to lead levels equal to or greater than 10 ug/dL.[3,4] Higher levels of lead exposure can result in serious health problems and can lead to coma, convulsions and death.[5]

Decreased academic performance has been linked to lead exposure during early childhood.[6] Children with lead exposure are more likely to have lowered IQ and behavioral problems, resulting in academic failure, need for special education services and increased risk for juvenile delinquency.[7,8] While all children are at risk for lead poisoning, low-income children and minority children are particularly likely to be affected.[9,10] The lack of affordable housing in many communities forces many low-income families to live in older dwellings with deteriorating lead paint, placing children at risk for exposure to lead-based paint chips and lead-contaminated dust and soil.[11,12] Inadequate nutrition and anemia, which are more common in low-income children, further increase susceptibility to lead poisoning.[13]

In Rhode Island in 2001, of the 464 children tested with a lead level over 20 ug/dL, three-quarters lived in one of the five core cities.[14] Of the 8 children hospitalized for lead poisoning, 7 were from Providence and 1 was from Pawtucket.[15] The Centers for Disease Control and Prevention recommends a comprehensive, multidisciplinary approach to the treatment of lead poisoned children, including repeat blood tests to monitor lead levels, medical management, house inspections, removal of lead hazards, child development services, social services and parent education.[16,17]

Results of Housing Inspections for Lead, Rhode Island, July 1999 – June 2000

# of Inspections Performed	272
Status of Inspections Performed	
Interior renovated and made lead safe	102
Open investigation (in process to become lead safe)*	71
Referred to court/local authorities for enforcement	44
Closed investigation with ongoing lead hazards still present	43
No lead violations found	5
Other	7
# of Inspections Offered and Not Completed	68
Total Number of Inspections Offered	340

** Property owners may be referred for prosecution if they fail to comply in a timely manner.*

◇ Rhode Island's Childhood Lead Poisoning Prevention Act requires that the state screen all children under 6 annually for lead exposure. A single test result of 20 ug/dL or greater or any two tests greater than 15 ug/dL within a 3 to 12 month period trigger a mandatory state-sponsored inspection of the child's home. The Department of Health sends certified lead inspectors to determine whether lead hazards are present and to work with property owners to make the property lead-safe.

◇ During fiscal year 2000, 340 housing inspections for lead were offered. Of these, 272 (80%) were performed. Inspections may not be performed because the child has moved or the tenant/homeowner does not respond.

◇ 43 investigations were closed with ongoing lead hazards still present. In many of these cases, the parent is the property owner and the case is closed because the Department of Health does not prosecute property owners to abate hazards in their own homes.

Sources: *Lead Poisoning in Rhode Island: The Numbers* (2001). Providence, RI: Rhode Island Department of Health, Division of Family Health and Rhode Island Department of Health, Office of Occupational and Radiological Health and Division of Family Health, 2001.

Table 16.

Lead Poisoning in Children Entering Kindergarten in the Fall of 2003

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	# SCREENED POSITIVE >=10 UG/DL	% CHILDREN >=10 UG/DL
Barrington	225	8	3.6%
Bristol	237	24	10.1%
Burrillville	179	22	12.3%
Central Falls	364	77	21.2%
Charlestown	77	6	7.8%
Coventry	388	15	3.9%
Cranston	844	68	8.1%
Cumberland	385	16	4.2%
East Greenwich	129	5	3.9%
East Providence	565	72	12.7%
Exeter	55	4	7.3%
Foster	42	0	0.0%
Glocester	92	6	6.5%
Hopkinton	95	7	7.4%
Jamestown	48	5	10.4%
Johnston	326	19	5.8%
Lincoln	194	14	7.2%
Little Compton	36	6	16.7%
Middletown	174	14	8.0%
Narragansett	138	7	5.1%
New Shoreham	18	1	5.6%
Newport	326	65	19.9%
North Kingstown	353	13	3.7%
North Providence	297	19	6.4%
North Smithfield	113	5	4.4%
Pawtucket	1,029	163	15.8%
Portsmouth	183	12	6.6%
Providence	2,963	660	22.3%
Richmond	85	5	5.9%
Scituate	148	5	3.4%
Smithfield	187	10	5.3%
South Kingstown	315	28	8.9%
Tiverton	161	10	6.2%
Warren	138	15	10.9%
Warwick	[illegible]	42	4.7%
West Greenwich	62	1	1.6%
West Warwick	366	26	7.1%
Westerly	147	19	12.9%
Woonsocket	704	137	19.5%
Unknown Residence	*476*	*31*	*6.5%*
Core Cities	*5,386*	*1,102*	*20.5%*
Remainder of State	*8,167*	*560*	*6.9%*
Rhode Island	*13,553*	*1,662*	*12.3%*

Lead Poisoning in Children Entering Kindergarten

◇ In the core cities, 21% of the children who will enter kindergarten in the fall of 2003 had a history of elevated lead levels, as compared to 29% of children entering kindergarten in the fall of 1999 and 45% in the fall of 1996. The core cities continue to have three times as many children entering kindergarten with lead exposure as the remainder of the state.[18]

Source of Data for Table/Methodology

Rhode Island Department of Health, Office of Occupational and Radiological Health and Division of Family Health, December 2001.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

Data for children entering kindergarten in the fall of 2003 reflects the number of RI children eligible to enter school in the Fall of 2003 (i.e., born between 9/1/97 and 8/31/98) who screened positive for lead poisoning at any time prior to December 2001. Rhode Island law requires universal lead screening for children under six. Lead screening results for close to 90% of Rhode Island children in this age cohort are included in this indicator.

The denominator is the number of children entering school in the fall of 2003 who were screened for lead poisoning.

References for Indicator

[1] *Protect Your Family from Lead in Your Home* (1999). Washington, DC: Environmental Protection Agency, United States Consumer Product Safety Commission, United States Department of Housing and Urban Development.

[2,3,4,5,6] *Screening Young Children for Lead Poisoning: Guidelines for State and Local Public Health Officials* (November 1997). Atlanta, GA: Centers for Disease Control and Prevention.

[3] Pueschel, S.M., Linakis, J.G., and Anderson, A.C. (1996). *Lead Poisoning in Childhood*. Baltimore, MD: Paul H. Brookes Publishing Company.

[8,9,11] *EPA Fact Sheet: Standards to Identify Dangerous Levels of Lead* (1998). Washington, DC: Environmental Protection Agency.

[9] *CDC's Lead Poisoning Prevention Program* (2000). Atlanta, GA: Centers for Disease Control and Prevention.

[10] *Coordinating Care from Clinic to Community: Quality Standards for Serving Children and Families Affected by Environmental Lead Hazards* (1998). Boston, MA: New England Serve.

[7] *Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children* (1999). Washington, DC: United States General Accounting Office.

[10] Alliance to End Childhood Lead Poisoning Web site (January 2001). www.aeclp.org.

[18,19] Rhode Island Department of Health, Division of Occupational and Radiological Health and Division of Family Health, January-December 2001.

[11] *Eliminating Childhood Lead Poisoning: A Federal Strategy Targeting Lead Paint Hazards* (2000). Washington, DC: President's Task Force on Environmental Health Risks and Safety Risks to Children.

[19] Rhode Island Department of Health, Division of Occupational and Radiological Health and Division of Family Health. Data are for children entering kindergarten in the fall of 2003, the fall of 1999 and the fall of 1996.

Children with Asthma

DEFINITION

Children with asthma is the annual number of hospitalizations for asthma among children under age 18. Data are reported by place of child's residence at the time of hospitalization.

SIGNIFICANCE

Asthma is a chronic breathing disorder that causes recurrent episodes of wheezing, breathlessness, chest tightness, and cough and can be life threatening.[1,2] Asthma attacks may occur when children get respiratory infections, including those caused by common cold viruses. Attacks can be triggered by: exposure to cigarette smoke, mold and dust in the home, stress, strenuous exercise, allergies, roach infestation, animal dander, indoor and outdoor pollutants, and weather conditions.[3,4,5] Childhood asthma in the U.S. increased from 40 per 1,000 children in 1982 to 65 per 1,000 children in 1998.[6] In 1998 in the United States, for every 10,000 children under age 18 there were 823 asthma outpatient visits, 124 asthma emergency room visits, and 25 asthma hospitalizations.[7]

Asthma is the first ranked cause of hospitalization in children under age 15.[8] Asthma is the leading cause of school absences resulting from chronic illness.[9] Black and Hispanic children are more likely to suffer from asthma. Racial differences in the prevalence of asthma are correlated with poverty, urban air quality, indoor allergens, and lack of patient education and adequate medical care.[10,11]

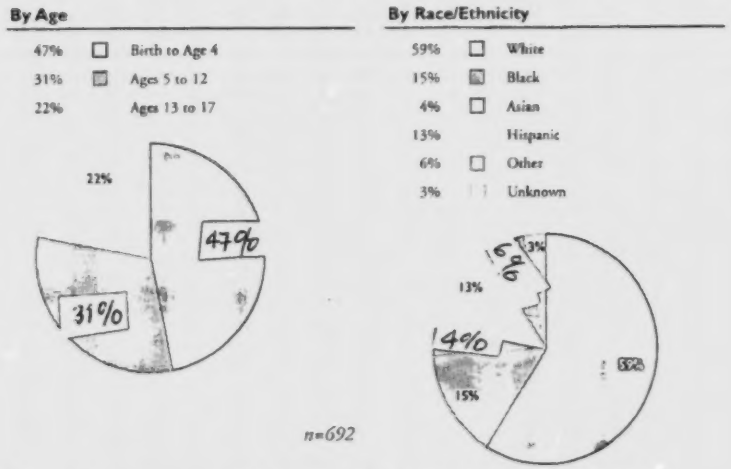
Managing asthma requires a long-term, multifaceted approach, including patient education, behavior modification, avoidance of asthma triggers, medication to minimize and prevent symptoms, prompt treatment, and frequent medical follow-up.[12,13] Insured children are twice as likely as uninsured children to receive ongoing asthma care from a physician. Low-income and uninsured children are more likely to receive treatment in the emergency department or be hospitalized for conditions that could have been managed with appropriate outpatient care.[14]

Childhood Asthma Hospitalization Rates, Core Cities and Rhode Island, 2000

City/Town	Number of Children Hospitalized	Rate per 1,000 Children
Central Falls	22	4.0
Newport	21	4.0
Pawtucket	63	3.5
Providence	241	5.3
Woonsocket	41	3.7
Core Cities	388	4.5
Rhode Island	692	2.8

Source: Rhode Island Department of Health, Hospital Discharge Database, January 1 - December 31, 2000.

Asthma Hospitalizations, Children Under Age 18, Rhode Island, 2000



Source: Rhode Island Department of Health, Hospital Discharge Database, January 1 - December 31, 2000.

Asthma in Rhode Island, 1998-2000

◇ More than half (55%) of all hospitalizations for childhood asthma between 1998 and 2000 were children residing in the core cities of Providence, Woonsocket, Pawtucket, Newport, and Central Falls, which also have the highest child poverty rates in the state.[15]

◇ While 27% of Rhode Island children are from a minority racial or ethnic group, 32% of hospitalizations for childhood asthma were Black, Asian, or Hispanic children.[16]

◇ Most cases of childhood asthma can be managed by the child's primary care physician and timely medical care can prevent severe asthma attacks. Hospitalization for asthma may indicate that the child has not had adequate outpatient management of the disease.[17,18] Asthma symptoms not severe enough to require hospitalization may still prevent a child from leading a fully active life.[19]

BEST COPY AVAILABLE

Table 17

Asthma Hospitalizations for Children, Rhode Island, 1998-2000

CITY/TOWN	ESTIMATED NUMBER OF CHILDREN UNDER 18	NUMBER OF ASTHMA HOSPITALIZATIONS	RATE/1000 CHILDREN
Barrington	14,235	11	0.8
Bristol	13,197	23	1.7
Burrillville	12,129	14	1.2
Central Falls	16,593	45	2.7
Charlestown	5,136	13	2.5
Coventry	25,167	28	1.1
Cranston	51,294	90	1.8
Cumberland	23,070	20	0.9
East Greenwich	10,692	14	1.3
East Providence	31,638	53	1.7
Exeter	4,767	4	0.8
Foster	3,315	6	1.8
Glocester	7,992	3	0.4
Hopkinton	6,033	5	0.8
Jamestown	3,714	1	0.3
Johnston	17,718	20	1.1
Lincoln	15,471	22	1.4
Little Compton	2,340	0	0.0
Middletown	12,984	32	2.5
Narragansett	8,499	13	1.5
New Shoreham	555	0	0.0
Newport	15,597	45	2.9
North Kingstown	20,544	30	1.5
North Providence	17,808	35	2.0
North Smithfield	7,137	5	0.7
Pawtucket	54,453	141	2.6
Portsmouth	12,987	21	1.6
Providence	135,831	541	4.0
Richmond	6,042	8	1.3
Scituate	7,905	6	0.8
Smithfield	12,057	16	1.3
South Kingstown	18,852	27	1.4
Tiverton	10,101	6	0.6
Warren	7,362	9	1.2
Warwick	56,340	92	1.6
West Greenwich	4,332	4	0.9
West Warwick	19,896	43	2.4
Westerly	16,218	23	1.0
Woonsocket	33,465	116	3.5
Unknown Residence	*NA*	*28*	*NA*
Core Cities	*255,939*	*888*	*3.5*
Remainder of State	*487,527*	*702*	*1.4*
Rhode Island	*743,466*	*1,618*	*2.2*

Source of Data for Table/Methodology

Rhode Island Department of Health, Hospital Discharge Database, 1998-2000. Data are for fiscal year 1998 and 1999 (June 1 to July 31) and calendar year 2000.

Core cities are Providence, Woonsocket, Pawtucket, Newport, and Central Falls.

The denominator is the total number of children under age 18 according to the 2000 Census of Population multiplied by three to compute a rate over three years, 1998-2000.

References for Indicator

[1] *Guidelines for the Diagnosis and Management of Asthma* (1997). Bethesda, MD: National Institutes of Health.

[2,3,8] *Asthma and the Environment: A Strategy to Protect Children* (2000). Washington, DC: President's Task Force on Environmental Health Risks and Safety Risks to Children.

[3,12] *Childhood Asthma* (1997). Milwaukee, WI: American Academy of Allergy, Asthma, and Immunology; and, *Asthma Prevention Program At-A-Glance* (1999). Atlanta: GA Centers for Disease Control and Prevention, National Center for Environmental Health.

[4] Vanderslice, R. and Bibeault, L. (July 1999). "Asthma and the Environment: A Physician's Guide to Resources, Research, and Data" in *Medicine and Health/Rhode Island*, Vol. 82, No. 7. Providence, RI: Rhode Island Medical Society.

[5,6] *Asthma in Children Fact Sheet* (1999). New York, NY: American Lung Association.

[7] *New Asthma Estimates: Tracking Prevalence, Health Care, and Mortality* (2001). Hyattsville, MD: National Center for Health Statistics.

[9,10,13] Rhode Island Department of Health, Hospital Discharge Database, 1998-2000.

[10] Asthma and Allergy Foundation of America Web site: www.aafa.org (November 2000).

[11] *Asthma: A Concern for Minority Populations* (1996). Bethesda, MD: National Institute of Allergy and Infectious Disease.

[12] *Pediatric Asthma: Promoting Best Practice – Guide for Managing Asthma in Children* (1999). Washington, DC: American Academy of Allergy, Asthma, and Immunology.

[14] *Health Insurance Coverage Leads to Increased Health Care Access for Children* (1997). Washington, DC: Government Accounting Office.

Births to Teens

DEFINITION

Births to teens is the number of births to teen girls ages 15 to 17 per 1,000 teen girls. Data are reported by the mother's place of residence, not the place of the infant's birth.

SIGNIFICANCE

Teen pregnancy and parenting threatens the development of teen parents as well as their children. Teen mothers are less likely to obtain adequate prenatal care and have the financial resources, social supports and parenting skills needed for healthy child development.[1] Children born to teen parents are more likely to suffer poor health, experience learning and behavior problems, live in poverty, go to prison, and become teen parents themselves.[2]

While teen pregnancy occurs in families of all income levels, teens who give birth are more likely to come from economically disadvantaged families and communities.[3] In the U.S., 83% of teens who give birth and 61% of teens who have abortions are from poor or low-income families.[4] Teen moms are more likely to have mothers who have completed fewer years of schooling and to have mothers or older sisters who also gave birth as adolescents.[5]

Poor academic achievement is a key predictor of teen pregnancy.[6,7] Nationally, three out of five teen mothers drop out of school. Being a teen parent seriously limits subsequent education and employment prospects.[8] Teen parents are more likely to delay or not finish school, putting them at greater risk of facing unemployment, low-wage jobs, and poverty.[9]

In Rhode Island between 1996 and 2000, there were 134 babies born to teen girls ages 12 to 14. There were 2,295 babies born to teens ages 15 to 17 and 4,044 births to teens ages 18 and 19. Between 1996 and 2000 in Rhode Island, 60% of births to teens resulted in live births, 37% resulted in abortion, and 3% resulted in miscarriage. In the core cities, 30% of pregnant teens ages 15 to 19 had abortions, compared to 46% of pregnant teens in the rest of Rhode Island. More than one in five (21%) births to teen girls ages 15 to 19 are to girls who have already given birth at least once.[10]

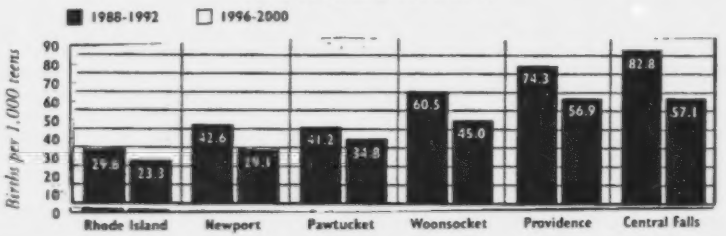
Teen Birth Rate
(births per 1,000 teens ages 15-17)

	1990	1998
RI	32	24
US	37	30
State Rank		*19th*

1st is best; 50th is worst

Source: *KIDS COUNT Data Book: State Profiles in Child Well-Being 2001* (2001). Baltimore, MD: The Annie E. Casey Foundation.

Births to Teens, Ages 15-17, Rhode Island and Core Cities, 1988-1992 and 1996-2000



◇ Teen birth rates for girls ages 15 to 17 have declined significantly in Rhode Island's core cities over the past decade. In Central Falls, the rate declined 31%, from 82.8 births to 57.1 births per 1,000 teens. Statewide the rate has decreased 22%, from 29.8 births to 23.3 births for every 1,000 teen girls ages 15 to 17.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1988-1992 and 1996-2000. Data for 1997-2000 are provisional.

Repeat Births to Teens, Ages 15 to 19, Rhode Island, 1996-2000

Age	Total Number of Births to Teens	Number of Repeat Births to Teens	Percent
15	348	12	3.4%
16	755	55	7.3%
17	1,192	175	14.7%
18	1,823	405	22.2%
19	2,221	665	29.9%
Total	6,339	*1,312*	20.7%

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1996-2000. Data for 1997-2000 are provisional.

◇ Between 1996 and 2000 in Rhode Island, one in five births to teens was to a teen who was already a mother. Of all births to girls ages 15 to 17, 11% were repeat births. Of all births to girls ages 18 and 19, 26% were repeat births.[11]

Table 18

Births to Teens, Ages 15-17, Rhode Island, 1996-2000

CITY/TOWN	# OF TEEN GIRLS AGES 15-17	# OF BIRTHS TO TEENS AGES 15-17	1996-2000 RATE PER 1,000 TEENS
Barrington	2,130	3	1.4
Bristol	1,860	23	12.4
Burrillville	1,785	14	7.8
Central Falls	1,875	107	57.1
Charlestown	670	14	20.9
Coventry	3,210	52	16.2
Cranston	6,890	95	13.8
Cumberland	3,125	28	9.0
East Greenwich	1,415	4	2.8
East Providence	4,565	54	11.8
Exeter	725	6	8.3
Foster	445	5	NA
Glocester	1,145	5	4.4
Hopkinton	870	13	14.9
Jamestown	565	1	1.8
Johnston	2,295	20	8.7
Lincoln	2,190	7	3.2
Little Compton	295	2	NA
Middletown	1,370	17	12.4
Narragansett	1,265	13	10.3
New Shoreham	80	0	NA
Newport	1,990	58	29.1
North Kingstown	2,660	21	7.9
North Providence	2,470	33	13.4
North Smithfield	1,015	8	7.9
Pawtucket	6,820	237	34.8
Portsmouth	1,680	12	7.1
Providence	17,055	970	56.9
Richmond	815	10	12.3
Scituate	1,215	6	4.9
Smithfield	1,750	9	5.1
South Kingstown	2,750	29	10.5
Tiverton	1,345	15	11.2
Warren	1,000	13	13.0
Warwick	7,910	95	12.0
West Greenwich	540	3	5.6
West Warwick	2,455	63	25.7
Westerly	2,170	39	18.0
Woonsocket	4,240	191	45.0
Core Cities	*31,980*	*1,563*	*48.9*
Remainder of State	*66,670*	*732*	*11.0*
Rhode Island	*98,650*	*2,295*	*23.3*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database. 1988-1992 and 1996-2000. Data for 1997-2000 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

NA: Rates were not calculated for cities and towns with less than 100 births, as rates for small denominators are statistically unreliable.

The denominator is the number of girls ages 15 through 17 according to the 2000 Census of Population, multiplied by five to compute a rate over five years, 1996-2000.

References for Indicator

[1] *The Right Start: Conditions of Babies and their Families in America's Largest Cities* (2002). Baltimore, MD: The Annie E. Casey Foundation.

[2] *The State of America's Children Yearbook 2001* (2001). Washington, DC: Children's Defense Fund.

[3,4] *When Teens Have Sex: Issues and Trends* (1999). Baltimore, MD: The Annie E. Casey Foundation.

[5] *Facts in Brief: Teen Sex and Pregnancy* (1997). New York: Alan Guttmacher Institute.

[6] *Why the Education Community Cares About Preventing Teen Pregnancy: Notes from the Field* (1998). Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[7,8] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database. 1996-2000. Data for 1997-2000 are provisional.

Alcohol, Drug, and Cigarette Use by Teens

DEFINITION

Alcohol, drug and cigarette use by teens is the percentage of seventh-grade, ninth-grade, and twelfth-grade students who have used alcohol or marijuana in the past month or are current smokers. Seventh-grade data are taken from the 2001 Youth Tobacco Survey. Ninth and twelfth-grade data are taken from the 2001 Rhode Island Youth Risk Behavior Survey.

SIGNIFICANCE

Adolescents are starting to use alcohol, tobacco and illicit drugs at younger ages.[1] The age when young people first start using alcohol, tobacco and illicit drugs is a predictor of later alcohol and drug problems, especially if use begins before age 15.[2]

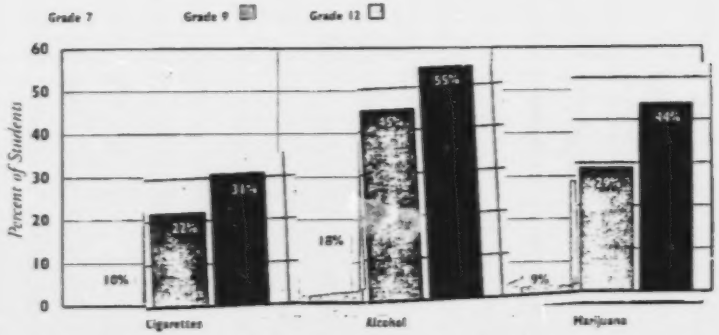
The use of these substances threatens the health and safety of children, families, and communities. Of the more than 2 million deaths each year in the United States, approximately one in four is attributable to alcohol, tobacco and illicit drug use.[3] The estimated cost of substance abuse in the United States is estimated at $414 billion.[4] Substance use can result in family violence and mistreatment of children.[5] Prenatal exposure to alcohol, tobacco, or drugs *in utero* is linked to psychological, cognitive, and physical problems in children.[6] Substance use, even at low levels, can increase the risk of suicidal ideas or attempts in teenagers.[7]

Children who are not engaged in school, have high rates of school failure, lack connections with caring adults, and have feelings of peer rejection are at risk of substance abuse during adolescence.[8,9,10,11] For both cigarette and alcohol use, the greatest risk factors among youths are frequent problems with school work and the number of friends who use either smoke or drink regularly.[12]

The health risks and consequences for tobacco use are serious for adolescents. If current smoking patterns continue, an estimated 5 million children and youths alive today will die prematurely of a smoking-related disease. Of these, 23,500 will be from Rhode Island.[13,14] Tobacco use among adolescents is a predictor of other drug use, especially among females.[15]

The number of Rhode Island juveniles referred to Family Court for alcohol and drug abuse violations in 2001 was 836. According to the National Institute on Drug Abuse, drug treatment reduces use by 40 to 60 percent.[16] Social skills training has been shown to reduce substance use in early adolescents.[17] Family and friends play critical roles in motivating substance abusers to enter treatment and maintain sobriety.[18]

Use of Cigarettes, Alcohol, and Marijuana, by Student Grade Level, Rhode Island, 2001



Student has used cigarettes, alcohol, or marijuana in the past month.

Sources: Seventh-grade data are from the *2001 Youth Tobacco Survey*, Rhode Island Department of Health, Office of Health Statistics. Ninth and twelfth-grade data are from the *2001 Rhode Island Youth Risk Behavior Survey*, Rhode Island Department of Health, Office of Health Statistics.

◇ Rhode Island students are using cigarettes and alcohol less now than they were in 1998.[19]

◇ In Rhode Island, nearly half of students have used alcohol by 9th grade. More than 40% of those who started drinking at age 14 or younger develop alcohol dependence.[20]

◇ Boys are more likely to use alcohol, tobacco and drugs in almost every grade. Girls are slightly more likely to use cigarettes in middle school.[21]

BEST COPY AVAILABLE

Adolescent Risk-Taking Behavior

According to the 2001 Rhode Island Youth Risk Behavior Survey:

◇ 14% of youth reported drinking and driving during the last thirty days. One out of three youth reported riding in a car in the last thirty days with someone who had been drinking. Thirty-one percent of youth reported binge drinking (consuming 5 or more drinks in a row) at least once in the last thirty days.[22]

◇ More than 1 out of 4 sexually-active teenagers used alcohol or drugs before their last sexual intercourse.[23]

◇ More than 1 out of 5 youths reported smoking their first cigarette before age 13.[24]

◇ Nearly 13% of youths reported trying marijuana for the first time before age 13.[25]

Club Drugs

Club drugs is a generic term referring to a group of drugs used by youth at all-night dance parties (raves or trances), dance clubs, and bars. These drugs are becoming increasingly popular among adolescents.[26]

◇ Club drugs are often used with other drugs. Combinations of drugs make them especially dangerous for users. Emergency room episodes involving club drugs usually involve multiple substances such as marijuana, cocaine, and especially alcohol.[27]

◇ Some common club drugs are MDMA (Ecstasy), GHB, Ketamine (Special K), Rohypnol (roofies), methamphetamine (speed), and LSD.[28]

◇ Since 1999, Ecstasy use among 12 to 18 year-olds has increased by 71% nationwide.[29] In 2000, 11% of high school students reported using Ecstasy at least once.[30]

References for Indicator

1,2,3,4,5,6,11,15,16 *Substance Abuse: The Nation's Number One Health Problem* (February 2001). Prepared by the Schneider Institute for Health Policy at Brandeis University for The Robert Wood Johnson Foundation. Princeton, NJ: The Robert Wood Johnson Foundation.

7 King, R. and Schwab-Stone, M. (July 2001). "Psychosocial and Risk Behavior Correlates of Youth Suicide Attempts and Suicidal Ideation" in *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 40, No. 7.

8,12 Blum, R.W., Beuhring, T., Rinehart, P.M. (2000). *Protecting Teens: Beyond Race, Income and Family Structure*. Minneapolis, MN: Center For Adolescent Health and The Robert Wood Johnson Foundation.

9 Whitaker, L. (2001). "Substance Abuse Prevention: What Works and What Doesn't" in *Advances*, Issue 2. The Robert Wood Johnson Foundation.

10,13,17 "Substance Abuse: Predicting It, Preventing It" in *SAMHSA News*, Vol. IX, No. 2. (Spring 2001).

14 *Investments in Tobacco Control: State Highlights* (2001). Atlanta, GA: Centers for Disease Control and Prevention, Office on Smoking and Health.

18 *Alcohol, Other Drugs, and Child Welfare Highlights* (2001). Washington, DC: Child Welfare League of America.

19 *Principles of Drug Addiction Treatment: A Research-Based Guide*. National Institute on Drug Abuse, National Institutes of Health (2000). Washington, DC: U.S. Department of Health and Human Services.

20 *1998 Rhode Island Adolescent Substance Abuse Survey Report of Statewide Results*. Rhode Island Department of Health, Office of Health Statistics.

21 *2001 Youth Tobacco Survey*. Rhode Island Department of Health, Office of Health Statistics.

22,23,24,25 *2001 Rhode Island Youth Risk Behavior Survey*. Rhode Island Department of Health, Office of Health Statistics.

26,28 *Club Drugs: Community Drug Alert Bulletin* (2001). Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse.

27 "Club Drugs: Emergency Room Update" in *SAMHSA News*, Vol. IX, No. 2. (Spring 2001).

29 *National Survey: Ecstasy Use Continues Rising Among Teens* (February 2002). Partnership for a Drug-Free America.

30 National Criminal Justice Reference Service Web site: www.ncjrs.org/club_drugs/club_drugs.html.

Additional Children's Health Issues

Adolescent Health Issues

Adolescents disproportionately engage in risky behaviors. As a result, these youth place themselves at greater risk of both immediate and long-term health consequences. The *2001 Youth Risk Behavior Survey* given to 9th to 12th graders in Rhode Island collected the following data related to adolescent physical and mental health:

◇ **Weapons.** 11% of Rhode Island students surveyed reported carrying a weapon of some kind one or more times in the 30 days preceding the survey; 5% carried a weapon on school property. Five percent of students reported carrying a gun. In the year preceding the survey, 9% of students reported being threatened or injured with a weapon on school property.[1]

◇ **Dating violence and rape.** During the 12 months preceding the survey, 9% of students were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend. Eight percent of students reported being forced to have sexual intercourse during their lives.[2]

◇ **Suicide.** Seventeen percent of students seriously considered attempting suicide during the 12 months before the survey. Twelve percent of students made a specific plan to attempt suicide. Overall, 8% of students attempted suicide one or more times.[3]

◇ **Sexual activity.** Nearly half (46%) of 9th to 12th grade students reported having sexual intercourse during their lifetime. More than 1 out of 10 students (11%) had initiated sexual intercourse when they were age 13 or younger. Seventeen percent of students ages 16 or 17 had four or more sexual partners in their lifetime.[4]

◇ **Pregnancy and STDs.** During their last sexual experience, 39% of sexually active students reported that they or their partner did not use a condom and 15% used no form of birth control at all.[5] Failure to use a condom and birth control puts youth who are sexually active at much greater risk of teen pregnancy and sexually transmitted diseases (STDs).[6,7]

◇ **Obesity.** Nearly 1 in 10 students is overweight. About 12% of students reported going without eating for more than 24 hours to lose weight or avoid gaining weight.[8]

Adolescent Health Care Access

◇ In 2000 in Rhode Island, an estimated 8,000 children ages 6 to 18 had no health insurance.[9]

◇ Even teens who have health insurance can have limited access to health care services. Only half (53%) of the children ages 12 to 21 who participated in the Neighborhood Health Plan of Rhode Island managed care plan received a well-child visit during 2000.[10]

◇ School-based health centers (SBHCs) are primary health care sites located within schools. SBHCs offer comprehensive physical and mental health services such as treatment of colds, care for chronic conditions such as asthma and diabetes, mental/behavioral health services, substance abuse services, physical and sports examinations, reproductive health care, dental care, and immunizations. Services are free for students without health insurance.[11]

◇ During the 1999-2000 school year, Rhode Island SBHCs provided over 9,000 services to students. During the 2000-2001 school year, 11,400 services were provided.[12]

◇ During 2000-2001 in Rhode Island, SBHCs provided 2,047 behavioral health services, 18% of the total services provided that year.[13] Nationally, behavioral services account for about 50% of the services provided by SBHCs.[14]

References

[1,2,3,4,5,6] *2001 Youth Risk Behavior Survey*. Rhode Island Department of Health.

[7] *Teenage Pregnancy: Overall Trends and State-by-State Information* (April 1999). New York, NY: The Alan Guttmacher Institute.

[8] *Demographic Characteristics of Reported Chlamydia, Gonorrhea and Syphilis Cases, Rhode Island 2000* (2001). Rhode Island Department of Health.

[9] US Census Bureau, Current Population Survey, 1999-2001 average.

[10] *Neighborhood Health Plan of Rhode Island, HEDIS 2001 Results: Adolescent Well-Care Visits* (August 2001). Providence, RI: Neighborhood Health Plan of Rhode Island.

[11] *School Based Health Center Services Help Teens Stay in School* (February 1999). Health Policy Briefs, Issue 99-2. Providence, RI: Rhode Island Department of Health.

[12,13] Rhode Island Department of Health (2001).

[14] *Report of the Special Senate Commission to Study School Based Health Centers* (May 2001). Providence, RI: Rhode Island Special Senate Commission to Study School Based Health Centers.

Childhood Immunizations

◇ Children need to be immunized according to the Childhood Vaccination Schedule to guard against preventable diseases that can cause serious long-term disabilities. Immunization during childhood reduces the risk of later medical problems and expenses. It is estimated that for every dollar spent on immunizations ten dollars is saved in later medical costs.[14]

◇ In 2000, 81% of Rhode Island children ages 19 to 35 months were fully immunized against childhood diseases, a higher rate than the national average of 73%.[15] Of the remaining children, most receive vaccinations before entering kindergarten.

◇ In 1999, the national full-series vaccination rates for children ages 19 to 35 months were higher among White children (81%) than among Black (74%) or Latino (75%) children.[16] While White infants ages 19 to 35 months have higher rates of vaccination receipt than do their Black and Hispanic counterparts, the national disparity in vaccination narrows over time and is nearly even as children enter preschool.[17]

◇ Although vaccination levels in the U.S. have been substantially increasing and racial and ethnic disparities in vaccination decreasing, children in households below the poverty level are still less likely to receive recommended vaccinations.[18]

Adolescent Immunizations

◇ Many adolescents are affected by diseases such as varicella (chicken pox), hepatitis B, measles and rubella. Routine visits to health care providers and access to health care services can ensure that adolescents are appropriately vaccinated against these preventable diseases.[19]

◇ Adolescents who have not been previously vaccinated against varicella and hepatitis B need those inoculations. Adolescents also require a second dose of measles, mumps, and rubella (MMR) vaccine and a booster dose against tetanus and diphtheria.[20]

◇ In order to ensure that all teenagers are appropriately vaccinated before they leave school, the Rhode Island Department of Health's Immunization Program partnered with the Rhode Island Immunization Action Coalition to create the Vaccinate Before You Graduate (VBYG) program. This program holds free vaccination clinics at high schools for any student who needs them. During the 2000-2001 school year, VBYG provided free vaccinations to 327 students at 32 high schools.[21]

References

[14] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation of New York.

[15] *2000-2001 Rhode Island Childhood Immunization Assessment.* Rhode Island Department of Health Immunization Program.

[16] *America's Children: Key National Indicators of Well-Being 2001* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[17,18] *Trends in the Well-Being of America's Children & Youth: 2000* (2001). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation.

[19,20] "Immunization of Adolescents: Recommendations of the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American Medical Association" (November 22, 1996). Washington, DC: Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report*, vol. 45, no. RR-13.

[21] "Vaccinate Before You Graduate" (2002). RI Department of Health Immunization Program in partnership with the RI Childhood Immunization Action Coalition.

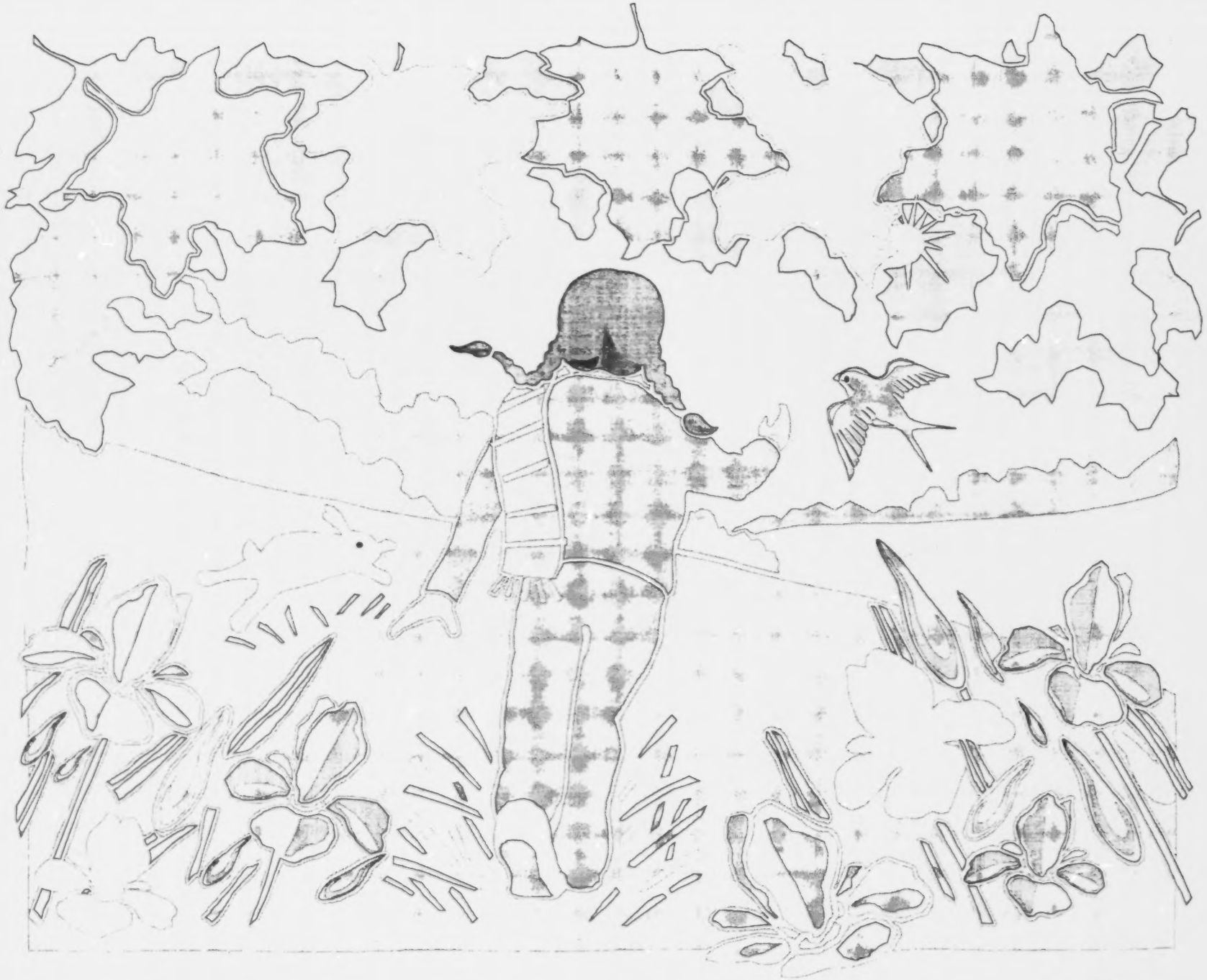
Safety

In Beauty May I Walk

Navajo

In beauty may I walk
All day long may I walk
Through the returning seasons may I walk
Beautifully will I possess again
Beautifully birds
Beautifully joyful birds
On the trail marked with pollen may I walk
With grasshoppers about my feet may I walk
With dew about my feet may I walk
With beauty may I walk
With beauty before me may I walk
With beauty behind me may I walk
With beauty above me may I walk
With beauty all around me may I walk
In old age, wandering on a trail of beauty,
lively, may I walk
In old age, wandering on a trail of beauty,
living again, may I walk
It is finished in beauty
It is finished in beauty

BEST COPY AVAILABLE



Child Deaths

DEFINITION

Child deaths is the number of deaths from all causes to children ages 1 to 14, per 100,000 children. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The child death rate is a reflection of the physical health of children, the dangers to which children are exposed at home and in the community, and the level of adult supervision children receive in the home.[1] Between 1996 and 2000 in Rhode Island there were 155 child deaths of children ages 1 to 14. Of these, 65% (100) were due to disease, 29% (45) were due to unintentional injuries and 6% were due to intentional injuries (10 homicides, 0 suicides).[2]

Unintentional injuries are the leading cause of death for children ages 1 to 14 in Rhode Island and nationally, exceeding deaths from any single disease.[3,4] Unintentional injuries and deaths due to such injuries disproportionately affect poor children, young children, males, rural children, children in families with low levels of education and employment, and minorities.[5] In the U.S., the death rate for Black children ages 1 to 4 is more than twice that for White children.[6] In Rhode Island in 1998 and 1999, 37% of child deaths older than one month involved minority children, although minority children were only 27% of the child population.[7]

Many of the injuries that do not result in death are extremely costly both financially and in terms of loss of quality of life. Injuries may leave children temporarily or permanently disabled, result in time lost from school, decrease the child's ability to participate in everyday activities, and affect future ability to work and be self-sufficient.[8]

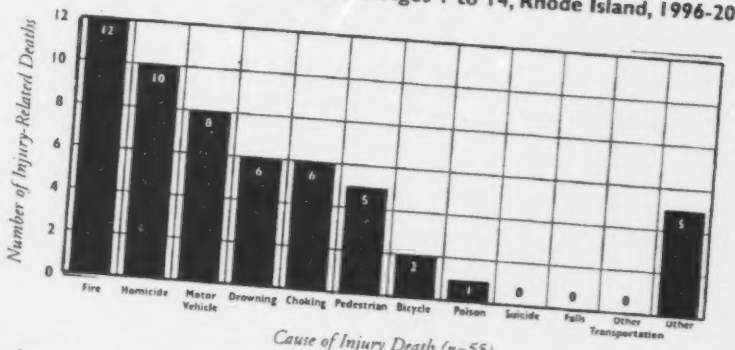
Child Death Rate
(per 100,000 Children Ages 1-14)

	1990	1998
RI	24	17
US	31	24
State Rank		3rd

1st is best; 50th is worst

Source: *KIDS COUNT Data Book: State Profiles in Child Well-Being 2001* (2001). Baltimore, MD: The Annie E. Casey Foundation.

Cause of Injury Deaths, Children Ages 1 to 14, Rhode Island, 1996-2000



Source: Rhode Island Department of Health. Maternal and Child Health Database. 1996-2000

◇ Motor vehicle accidents are a leading cause of injury deaths to children ages 1 to 14 in Rhode Island and nationally. In the U.S., approximately 51% of motor vehicle occupants ages 1 to 4 and 61% of motor vehicle occupants ages 5 to 14 years old who were killed in fatal crashes in 1998 were not properly restrained.[9]

◇ In 2001 the Rhode Island General Assembly passed legislation that requires children under age 7 and under 80 pounds to be properly restrained in a child restraint system.[10]

◇ The most effective injury prevention approaches are comprehensive and use multiple strategies such as: public policy changes reinforced through safety or environmental legislation and regulation; community-based effort to change social norms and behaviors related to safety; and individualized education, such as one-on-one counseling by a health professional in a clinical setting.[11]

Table 19.

Child Deaths, Rhode Island, 1996-2000

CITY/TOWN	NUMBER OF CHILDREN AGES 1-14	NUMBER OF CHILD DEATHS	RATE PER 100,000
Barrington	18,630	2	NA
Bristol	17,245	3	NA
Burrillville	15,540	1	NA
Central Falls	22,045	3	NA
Charlestown	6,665	0	NA
Coventry	33,330	9	NA
Cranston	66,655	4	NA
Cumberland	30,500	2	NA
East Greenwich	14,360	0	NA
East Providence	41,025	7	NA
Exeter	6,230	4	NA
Foster	4,385	1	NA
Glocester	10,360	1	NA
Hopkinton	7,830	2	NA
Jamestown	4,920	0	NA
Johnston	23,595	2	NA
Lincoln	20,390	4	NA
Little Compton	3,045	0	NA
Middletown	17,540	1	NA
Narragansett	10,825	3	NA
Newport	20,545	1	NA
New Shoreham	735	0	NA
North Kingstown	27,055	4	NA
North Providence	23,190	5	NA
North Smithfield	9,230	1	NA
Pawtucket	71,750	16	NA
Portsmouth	17,225	3	NA
Providence	178,850	38	NA
Richmond	7,940	4	NA
Scituate	10,220	1	NA
Smithfield	15,620	0	NA
South Kingstown	24,485	0	NA
Tiverton	13,250	3	NA
Warren	9,525	1	NA
Warwick	73,290	13	NA
Westerly	21,120	4	NA
West Greenwich	5,685	1	NA
West Warwick	26,065	5	NA
Woonsocket	43,930	6	NA
Core Cities	*337,120*	*64*	*19.0*
Remainder of State	*637,705*	*91*	*14.3*
Rhode Island	*974,825*	*155*	*15.9*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, 1996-2000. Data for 1997-2000 are provisional. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

NA: Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of children ages 1 to 14 according to the 2000 Census of Population, multiplied by five to compute a rate over five years, 1996-2000.

References for Indicator

[1] *A Data Book of Child and Adolescent Injury* (1991). Washington, DC: Children's Safety Network.

[2] Rhode Island Department of Health, Maternal and Child Health Database, 1996-2000. Data for 1997-2000 are provisional.

[3] *America's Children: Key National Indicators of Well-Being* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[4] Jenny C., et al. (2001). *Rhode Island Child Death Report for the Two-Year Period 1998 and 1999.* Providence, RI: Brown University School of Medicine, Department of Pediatrics and Hasbro Children's Hospital, Child Protection Program, in partnership with Rhode Island KIDS COUNT.

[5] *Childhood Injury Fact Sheet* (December 1999). Washington, D.C.: National Safe Kids Campaign.

[6] Miller, T.R., Romano, E.O., and Spicer, R.S. (Spring/Summer 2000). "The Cost of Childhood Injuries and the Value of Prevention" in *The Future of Children*, Vol. 10, No.1. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[7] State of Rhode Island, Public Laws 01-132.

[8] DiGuiseppi, R. (Spring/Summer 2000). "Individual-Level Injury Prevention Strategies in the Clinical Setting" in *The Future of Children*, Vol. 10, No.1. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

Teen Deaths

DEFINITION

Teen deaths is the number of deaths from all causes to teens ages 15 to 19, per 100,000 teens. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The transition to adulthood confronts teens with health and safety risks. Teens are more likely than any other age group to take risks that can cause injury to themselves or others. Factors contributing to teen deaths include risk-taking behavior, the use of alcohol and drugs, and violence.[1] In 1998 and 1999 in Rhode Island, 73% of deaths of teens between ages 14 and 18 were preventable. Nationally and in Rhode Island, the two leading causes of death for teens ages 15 to 19 are motor vehicle traffic accidents and firearm injuries.[2,4]

Between 1996 and 2000, 43% of Rhode Island's teen deaths were due to unintentional injuries. Of the 70 teen deaths due to unintentional injuries, 51% were due to motor vehicle collisions.[5] Rhode Island youth surveys reveal that most youth do not use safety belts and that they frequently combine alcohol consumption with driving.[6]

Between 1996 and 2000, 30% of the deaths among Rhode Island teens were due to the intentional injuries — homicide (25 deaths) and suicide (23 deaths).[7] The Rhode Island Suicide Prevention Team, coordinated by the Violence Prevention Program of the Rhode Island Department of Health, is currently formulating a comprehensive suicide prevention framework for youth between ages 15 and 24, with particular attention to improving access to mental health services for youth.[8]

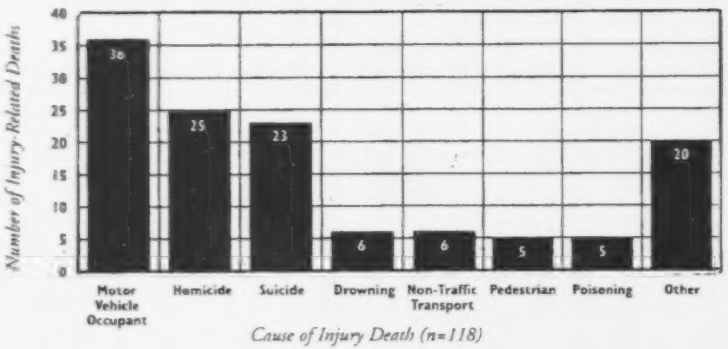
Teen Deaths by Accident, Homicide and Suicide,
(deaths per 100,000 teens ages 15-19)

	1990	1998
RI	35	33
US	71	54
State Rank		*1st*

1st is best; 50th is worst

Source: *KIDS COUNT Data Book: State Profiles in Child Well-Being 2001* (2001). Baltimore, MD: The Annie E. Casey Foundation.

Cause of Injury Deaths, Teens Ages 15 to 19, Rhode Island, 1996-2000



Cause of Injury Death (n=118)

◇ Between 1996 and 2000, the leading causes of death due to injuries for Rhode Island teens ages 15 to 19 were motor vehicle accidents (36 deaths), homicide (25 deaths), and suicide (23 deaths).

◇ In Rhode Island, the teen death rate from all causes dropped from 47.1 deaths per 100,000 teens in 1987-1991 to 42.7 deaths per 100,000 teens in 1996-2000. There were 182 teen deaths between 1987 and 1991 compared to 161 teen deaths between 1996 and 2000.

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1996-2000. Data for 1997-2000 are provisional.

Gun Deaths and Gun-Related Hospitalizations, Rhode Island, 1996-2000

Between 1996 and 2000 in Rhode Island:

◇ There were 27 gun deaths to teens ages 15 to 19 and 6 gun deaths involving children ages 14 and younger.[9]

◇ 69 children were hospitalized with gunshot wounds. Of these, 11 of the victims were younger than age 15, and 58 were between the ages of 15 and 19; 47 were intentional injuries, 18 were unintentional, and 4 were undetermined.[10]

Teen Deaths, Rhode Island, 1996-2000

Table 20

CITY/TOWN	NUMBER OF TEENS AGES 15-19	NUMBER OF TEEN DEATHS	RATE PER 100,000
Barrington	5,965	1	NA
Bristol	10,525	2	NA
Burrillville	6,020	3	NA
Central Falls	7,205	5	NA
Charlestown	2,180	1	NA
Coventry	10,260	7	NA
Cranston	23,660	12	NA
Cumberland	9,360	2	NA
East Greenwich	4,055	2	NA
East Providence	14,250	7	NA
Exeter	2,140	2	NA
Foster	1,415	1	NA
Glocester	3,630	3	NA
Hopkinton	2,570	0	NA
Jamestown	1,505	2	NA
Johnston	7,205	5	NA
Lincoln	6,390	3	NA
Little Compton	1,035	1	NA
Middletown	4,520	1	NA
Narragansett	4,960	1	NA
Newport	9,930	2	NA
New Shoreham	215	0	NA
North Kingstown	8,110	3	NA
North Providence	8,060	0	NA
North Smithfield	3,140	2	NA
Pawtucket	23,120	9	NA
Portsmouth	5,105	2	NA
Providence	89,785	43	NA
Richmond	2,310	2	NA
Scituate	3,535	1	NA
Smithfield	10,555	2	NA
South Kingstown	20,585	4	NA
Tiverton	4,465	1	NA
Warren	3,325	2	NA
Warwick	24,790	8	NA
Westerly	7,045	5	NA
West Greenwich	1,810	0	NA
West Warwick	8,590	7	NA
Woonsocket	13,900	5	NA
Unknown	*0*	*2*	*NA*
Core Cities	*143,940*	*64*	*44.5*
Remainder of State	*233,285*	*97*	*41.6*
Rhode Island	*377,225*	*161*	*42.7*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, 1996-2000. Data for 1997 to 2000 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of teens ages 15 to 19 according to the 2000 Census of Population, multiplied by five to calculate a rate over five years, 1996-2000.

References for Indicator

[1] *Losing Generations: Adolescents in High Risk Settings* (1993). Washington, DC: National Academy Press.

[2] Jenny, C. et al. (2001). *Rhode Island Child Death Report for the Two-Year period 1998 and 1999.* Providence, RI: Brown University School of Medicine, Department of Pediatrics and Hasbro Children's Hospital, Child Protection Program, in partnership with Rhode Island KIDS COUNT.

[3] *America's Children: Key National Indicators of Well-Being* (2001). Washington, DC: Interagency Forum on Child and Family Statistics.

[4] *Kids in the Line of Fire* (2001). Washington, DC: Violence Policy Center.

[5,6] Rhode Island Department of Health, Maternal and Child Health Database, 1996-2000.

[7] *1997 Rhode Island Youth Risk Behavior Survey* (1998). Providence, RI: Rhode Island Department of Health.

[8] *A Draft Suicide Prevention Framework for Rhode Islanders Ages 15-24* (September 2001). Providence, RI: Rhode Island Department of Health, Violence Prevention Program.

[9] Rhode Island Department of Health Hospital Discharge Database, 1996-2000.

Homeless Children

DEFINITION

Homeless children is the number of Rhode Island children under 13 years old who received emergency housing services at emergency homeless shelters and domestic violence shelters between July 1, 2000 and June 30, 2001.

SIGNIFICANCE

Poverty, lack of affordable housing, and domestic violence are factors in family homelessness.[1,2,3] With a large percentage of family income going toward rent, any interruption in income or unexpected expense can place families at risk of homelessness.[4] The shortage of affordable apartments and the dwindling availability of subsidized housing have caused many Rhode Island families to double-up, resulting in overcrowded, unstable living conditions. More than a third (35%) of families with children in the Rhode Island shelter system had been doubled up with family members or friends just before moving to the shelter. Fifteen percent had most recently been at another shelter.[5]

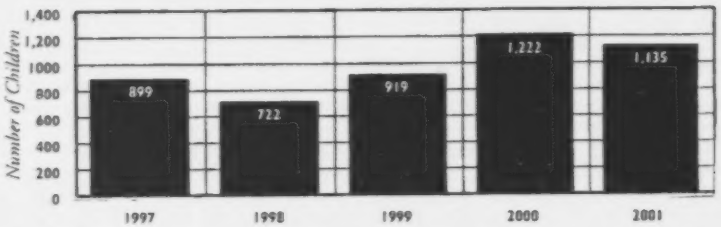
Family homelessness in the United States has increased during the last 15 years.[6] In the U.S., more than 40% of the homeless are women and children – the fastest growing homeless group.[7] Homeless children are more likely to get sick, have poor nutrition, develop mental health problems, have academic problems, and experience violence than children who are not homeless.[8] Infants, toddlers and preschoolers who are homeless develop more slowly and may develop emotional problems serious enough to require professional care.[9]

Between July 1, 2000 and June 30, 2001, there were 1,260 children under age 18 who received shelter from Rhode Island's emergency and domestic violence shelter system: Of these, 678 (54%) were age 5 or under, 457 (36%) were ages 6 to 12, and 125 (10%) were ages 13 to 17.[10] Nearly 80% of the families that used the Rhode Island shelters in 2001 were headed by single women. Seventy percent of these families had incomes between $5,000 and $15,000 per year, 69% were receiving cash assistance through the Family Independence Program, and 27% had income from employment during the six months prior to seeking shelter.[11]

Emergency Shelter in Rhode Island

◇ The Emergency Shelter system in Rhode Island is at maximum capacity. Shelters that were previously available to families to provide temporary shelter now remain full as more parents and children are unable to leave because affordable housing is not available. The average length of stay for children in shelters was 41 nights in 2001, a record high.[12]

Homeless Children Under Age 13, Rhode Island, 1997 - 2001



Source: RI Emergency Shelter Information Project Annual Reports, 1997 – 2001. Providence, RI: RI Emergency Food and Shelter Board.

Homeless Children and Education

◇ School-age children who are homeless face academic and emotional problems that hinder success in school.[13] Length-of-stay restrictions in shelters, short stays with friends or relatives, and family relocation to seek employment make it difficult for homeless children to attend school regularly.[14]

◇ Homeless children are often prevented from enrolling in school due to guardianship requirements, delays in transfer of school records, lack of a permanent address, and lack of immunization records. Once children are enrolled, transportation to and from school can become an obstacle for families without a car or money for public transportation.[15]

◇ Children who are homeless are more likely to repeat a grade or to be suspended. They are more likely to be learning disabled, but are less likely to receive treatment for their learning disabilities and less likely to receive special education services.[16]

◇ In 1987, Congress established the McKinney Act's Education of Homeless Children and Youth Program to ensure that all homeless children and youth have equal access to the same free, appropriate education provided to other children and youth. McKinney funds are used by state and local educational agencies to review and revise policies and practices that act as barriers to school enrollment, attendance and success for homeless children.[17]

DEFINITION

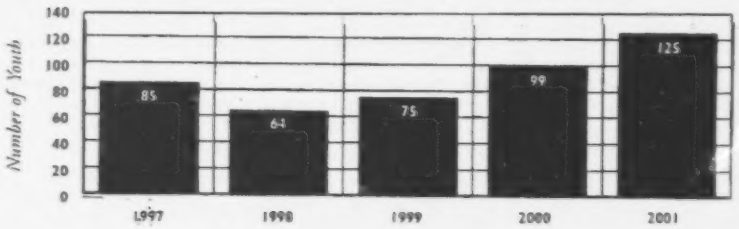
Homeless youth is the number of Rhode Island youth ages 13 to 21 who are homeless or at risk for homelessness, have run away from home, or have been thrown out of their home and not allowed to return.

SIGNIFICANCE

Homelessness among youth has a number of causes, including family problems (such as strained relationships or physical abuse), poverty, family homelessness, and residential instability resulting from foster care or institutional placements.[1] Some runaway youth are considered to be "throw-aways" who were told to leave a household, were abandoned or deserted, or tried to return home and were denied access.[2] Homeless youth are at risk of being physically and/or sexually victimized, abusing drugs and alcohol, attempting suicide, becoming victims or perpetrators of crime, receiving money for sex to meet their basic survival needs, and contracting HIV/AIDS.[3]

Rhode Island does not have an overnight shelter for runaway youth. During 2001, an estimated 600 youth ages 13 to 17 accessed services offered by Travelers Aid, which include crisis intervention, counseling, case management, respite and referral services.[4,5]

Homeless Youth, Ages 13–17, Rhode Island Emergency Shelter System, 1997 to 2001



◇ Between 1997 and 2001, the number of youth who received shelter from the Rhode Island emergency or domestic violence shelter system increased from 85 to 125.[6] This is an underestimate of the total number of youth in need of shelter, as many of the emergency and domestic violence shelters do not accept males over the age of twelve.

DCYF Night-to-Night Placements and Unauthorized Absence

◇ Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting permanent foster care placement, a group home/treatment placement, or who have run away from their current placement. During 2001, an average of 20 adolescent boys and 26 adolescent girls per month were in night-to-night placements.[7]

◇ As of December 31, 2001, there were 127 youth in DCYF care who were classified as unauthorized absence/runaways.[8]

References for Indicators

Homeless Children

[1,2,3,4] *Homeless Children: America's New Outcasts* (1999). Newton, MA: The Better Homes Fund.

[2] *Homeless Families With Children NCH Fact Sheet #7* (June 1999). Washington, DC: National Coalition for the Homeless.

[3] *A Status Report on Hunger and Homelessness in America's Cities* (2000). U.S. Conference of Mayors.

[4] *Children and Their Housing Needs: A Report to KIDS COUNT* (1993). Washington, DC: Center on Budget and Policy Priorities.

[5] *Homeless in America: A Children's Story, Part One* (1999). New York, NY: Homes for the Homeless and The Institute for Children and Poverty.

[6,7,8] *Rhode Island Emergency Shelter Information Project Annual Report, July 1, 2000-June 30, 2001* (2002). Providence, RI: RI Emergency Food and Shelter Board.

[8] *Education of Homeless Children NCH Fact Sheet #10* (June 1999). Washington, DC: National Coalition for the Homeless.

Homeless Youth

[1] *NCH Fact Sheet #11: Homeless Youth* (1999). Washington, DC: National Coalition for the Homeless.

[2] Schneider, D. (1995). *American Childhood: Risks and Realities*. Princeton, NJ: Rutgers University Press.

[3] *Youth with Runaway, Throw-aways, and Homeless Experiences: Prevalence, Drug Use, and Other At-Risk Behaviors* (1995). Washington, DC: Family and Youth Service Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

[4,5] Travelers Aid, Providence, RI: Year-End Reports, 2001.

[6] Rhode Island Emergency Shelter Information Project, 1997-2001. Providence, RI: Rhode Island Emergency Food and Shelter Board.

[7] Rhode Island Office of the Child Advocate, January 2002.

[8] Rhode Island Department of Children, Youth and Families, December 2001.

Juveniles Referred to Family Court

DEFINITION

Juveniles referred to Family Court is the percentage of youth ages 10 to 17 referred to Rhode Island Family Court for all wayward and delinquent offenses.

SIGNIFICANCE

Poor school performance, including chronic truancy and falling behind one or more grade levels, increases the likelihood of involvement with the juvenile justice system. Other risk factors include poverty, family violence, inadequate supervision, limited education and job skills, substance abuse, and mental health problems.[1,2,3] Most juvenile crime takes place in the after-school and early evening hours.[4]

During 2001 in Rhode Island, 5,896 youth were taken into custody and 4,746 were referred to Family Court.[5,6] More than half (59%) of juveniles referred to Family Court were White, 17% Black, 13% Hispanic, 2% Asian or Pacific Islander and 9% unknown.[7]

The Rhode Island Family Court has jurisdiction over all juvenile offenders referred for wayward and delinquent offenses. All referrals to Family Court are from state and local law enforcement agencies, except for truancy cases that are referred by local school departments. Approximately one-third of all cases referred to Family Court are diverted instead of proceeding to a formal court hearing. Juveniles who commit crimes involving drugs may be referred by the Family Court to the Juvenile Drug Court, rather than proceeding through the regular juvenile court system.[8] Juveniles referred to the Drug Court undergo a six- to twelve-month program that includes intensive court supervision, drug treatment, school performance reviews, job placement, and development of social skills and interests outside the drug culture.[9]

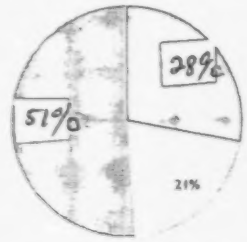
Rhode Island Family Court also administers 27 Juvenile Hearing Boards serving 29 communities that permit the diversion of juveniles accused of status offenses or misdemeanors. Sanction options in this diversion process include community service, restitution, mental health or substance abuse counseling, and/or other community-based program.[10] In 2001, 852 referrals were made to Juvenile Hearing Boards. Over three-quarters of juveniles referred to Hearing Boards for whom race/ethnicity data was available were White.[11]

Prevention and early intervention are the most cost-effective approaches to reducing delinquency and recidivism.[12,13] Successful programs involve highly-trained counselors who work with youth, their families and teachers to promote responsible behavior, implement systems of support and build on assets and strengths.[14]

Juvenile Wayward/Delinquent Offenses Referred to Family Court, Rhode Island, 2001

By Residence of Offender

28%	Providence
21%	Other Core Cities
51%	Remainder of State

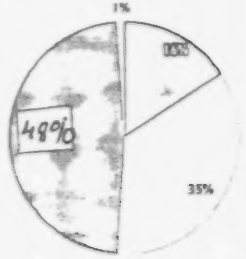


By Gender of Juvenile

76%	Male
24%	Female

By Age of Juvenile

16%	Ages 13 or Younger
35%	Ages 14 and 15
48%	Ages 16 and 17
1%	Over age 17



◇ In 2001 there were 4,746 Rhode Island juveniles (4% of youth ages 10 to 17) referred to Family Court for 8,465 wayward and delinquent offenses.

n=8,465 offenses

Source: Rhode Island Family Court, Juvenile Offense Report, 2001.

BEST COPY AVAILABLE

Juvenile Wayward/Delinquent Offenses Referred to Family Court, by Type of Offense, Rhode Island, 2001

29%	Property Offenses	9%	Traffic Offenses
16%	Status Offenses*	5%	Violent Crime Offenses
13%	Disorderly Conduct	2%	Weapons Offenses
12%	Simple Assaults	4%	Other**
10%	Alcohol and Drugs		

n = 8,465

**Status offenses are age-related acts that would not be punishable if the offender were an adult, such as truancy and disobedient conduct.*

***Other includes offenses such as false report of a crime, conspiracy, crank/obscene phone calls, and escapes from custody.*

Source: Rhode Island Family Court, Juvenile Offense Reports for 2001

Interventions for Youth at Risk of Chronic Delinquency

◇ Studies indicate that a small group of youth is responsible for the majority of all serious and violent juvenile crimes. Identifying youth who are at risk of becoming chronic and serious offenders is the first step towards preventing juvenile crime. Poor school performance, behavior and attendance; family problems; substance abuse; patterns of stealing, running away or gang membership are predictors of delinquency.[15]

◇ An effective approach to preventing chronic delinquency includes a comprehensive and intensive program for youth identified as being at-risk. Such a program includes all-day academic and youth development programming, family involvement and counseling, and a focus on treating substance abuse.[16]

Juveniles Tried as Adults

◇ When a juvenile has committed a heinous and/or premeditated felony offense or has a history of felony offenses, the Attorney General may request that the Family Court Judge waive jurisdiction so that the juvenile may be tried as an adult in Superior Court. Waiver is mandatory for juveniles age 17 or older who are charged with murder, first degree sexual assault or assault with intent to commit murder.[17]

◇ A juvenile may also be certified allowing a court to sentence the juvenile to age 21 or beyond if there is otherwise an insufficient period of time in which to accomplish rehabilitation. While the youth is a minor, the sentence is served at the Training School; upon reaching majority the youth is transferred to an adult facility.[18]

◇ In 2001, the Attorney General's Office filed 18 motions to waive jurisdiction to try juveniles as adults. Six motions to waive were withdrawn and five were waived out of Family Court to adult court. In January 2002, there were seven motions pending before the Family Court.[19]

References for Indicator

[15] *Juvenile Offenders and Victims: 1999 A National Report* (1999). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Departments of Justice.

[16] *Great Transitions: Preparing Adolescents for a New Century* (1995). New York: Carnegie Council on Adolescent Development.

[17] Bilchik, S. (July 1998). *OJJDP Fact Sheet #82*. Mental Health Disorders and Substance Abuse Problems Among Juveniles. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[18] Chaiken, M.R. (June 1998). *Issues and Practices in Criminal Justice: Kids, COPS, and Communities*. Washington, DC: U.S. Department of Justice, National Institute of Justice and The Carnegie Corporation of New York.

[19] Rhode Island Justice Commission, Juvenile Detention Data Summary, January 2002.

[20] Rhode Island Family Court, 2001 Juvenile Offense Report.

[21] Rhode Island Family and Juvenile Drug Court, Newsletter, Issue 1: Winter 2000.

[22] Pirolli, R. (2002) 2001 *Juvenile Hearing Board Year-End Report Summary*. Providence, RI: Rhode Island Family Court.

[23] *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (1995). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Department of Justice.

[24] Mendel, R. *Less Cost More Safety: Guiding Lights for Reform in Juvenile Justice* (2001). Washington, DC: The America Youth Policy Forum.

[25] R.I. Gen. Laws sections 14-1-7; 14-1-7.1;14-1-7.2; 14-1-7.3.

[26] Rhode Island Office of the Attorney General, 2001.

Juveniles at the Training School

DEFINITION

Juveniles at the training school is the number of juveniles up to age 21 who were in the care and custody of the Rhode Island Training School at any time during the 2001 calendar year. The total includes youth who spent time at the Training School and/or in other community placements while in the care and custody of the Training School.

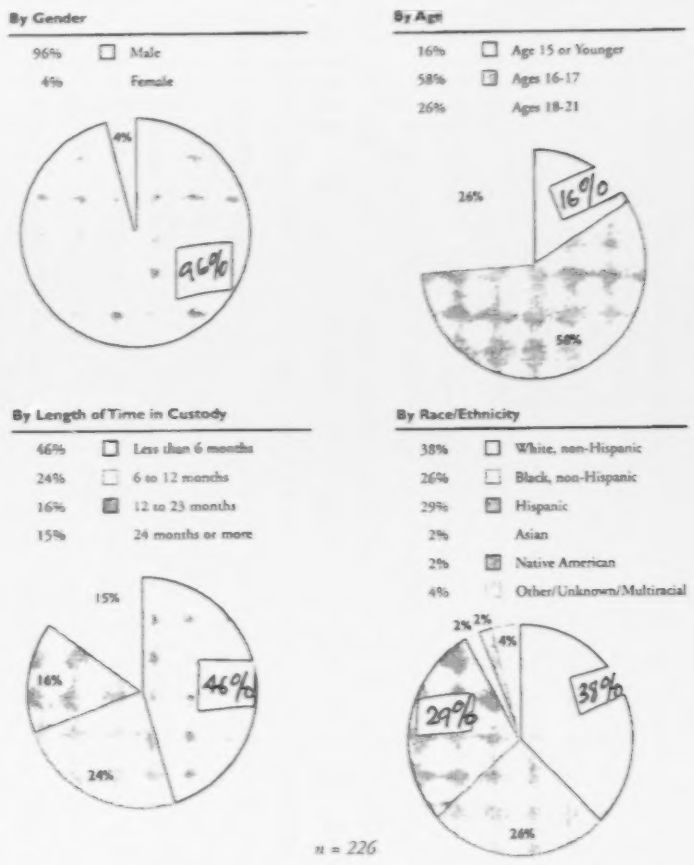
SIGNIFICANCE

Juvenile detention facilities must balance public safety with the need for treatment and rehabilitation of young offenders.[1] A combination of persistent poverty, school problems, family issues, drug use, and/or unmet mental health and special education needs are associated with risk for involvement with the juvenile justice system. Nationwide only a fraction of incarcerated youth are violent and dangerous. Most are incarcerated for drug and property offenses that could be addressed through diversion programs. Black youth are incarcerated at more than twice the rate of White youth. Community placements can help address the large racial disparity among incarcerated youth.[2,3,4]

Research indicates that alternatives to incarcerating youth are both more successful in preventing recidivism and are more cost-effective. Successful efforts include comprehensive community-based strategies that identify risks for youth; focus on prevention, diversion and rehabilitation; and address reintegration into the community.[5] A graduated system of sanctions, treatment and step-down programs can minimize recidivism.[6] In general, for delinquent but non-dangerous youth, sanctions such as community service and restitution or diversion to drug court and substance abuse treatment are more effective than incarceration.[7]

The Department of Children Youth and Families operates the Rhode Island Training School for Youth, the state's residential detention facility for adjudicated youth and youth awaiting trial. There were a total of 1,043 youth in the care and custody of the Training School at some point during calendar year 2001. As of December 31, 2001, there were 180 youth on the grounds at the Training School. Of these, 28 were unadjudicated (i.e., awaiting trial). An additional 105 youth were within the care and custody of the Training School in temporary home or community placements. Ten additional youth were classified as runaways.[8]

Juveniles in the Care and Custody of the Rhode Island Training School for Youth, December 31, 2001



n = 226

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 31, 2001. Data are for adjudicated youth only and include youth in community placements.

BEST COPY AVAILABLE

Rhode Island Youth at the Training School, 2001

School Failure

◇ A survey of educational records of Training School youth confirm significant academic difficulty. Based on a random review of 78 records on December 1, 2001, 62% (48) had no records available or no records indicative of grades for the past two years. Of the 30 students who had any school records for the previous two years, half had failing grades and half had passing grades. The average age of the students was 17. Their average self-reported grade placement was 10th grade and their average reading and math grade level was 5th grade.[9]

Special Education and Mental Health Issues

◇ The cause of delinquent behavior may be directly related to a child's undetected and/or inadequately treated disability.[10,11] At the Rhode Island Training School on December 1, 2001, approximately 41% of adjudicated and unadjudicated residents were receiving special education services, primarily due to learning disabilities and behavior disorders.[12] This is almost twice the rate of students receiving special education services in Rhode Island public schools in 2001.[13]

◇ On December 1, 2001, 10% of students at the Training School were receiving psychiatric care and 53% were receiving substance abuse treatment.[14]

◇ Appropriate special education and mental health services are critical to both prevent delinquency and assist in rehabilitation. School failure, unexcused absences, chronic disciplinary problems and grade retention may be associated with a disabling condition that has not been detected.[15]

History of Child Abuse or Neglect

◇ Approximately 38% of the adjudicated youth within the care and custody of the Training School on December 31, 2001 (including community placements) had at some point in their childhood been victims of documented abuse or neglect.[16]

Prevention of Recidivism Among Delinquent Youth

◇ On December 31, 2001, 67% of the youth in the care and custody of the Training School had been admitted to the Training School at least twice. One in five (19%) had been admitted to the Training School at least four times.[17]

◇ Research indicates that early identification and treatment of youth at risk for chronic delinquency, and immediate, intensive intervention involving the youth and his or her family in counseling, all-day academic programming and substance abuse treatment or counseling are effective in reducing chronic delinquency.[18]

◇ For serious, repeat and violent juvenile offenders, the quality of rehabilitative services is critical, since most will be returned to the community. A successful model of rehabilitation for serious and violent juveniles includes intensive academic and physical work, earning credit through behavior to hasten release, trained staff and small staff/inmate ratios and groups, and a heavy focus on transition planning and aftercare services.[19]

References

[illegible] Puritz P. et al. (1998). *Beyond the Walls: Improving Conditions of Confinement for Youth in Custody.* Washington, DC: American Bar Association Juvenile Justice Center and U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[illegible] *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (1998). Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[illegible] Devine, P. et al. (December 1998). *Disproportionate Minority Confinement: Lessons Learned From Five States.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[illegible] *Minorities in the Juvenile Justice System, 1999 National Report Series* (December 1999). Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[illegible] Mendel, R. (2001). *Less Cost, More Safety: Guiding Lights for Reform in Juvenile Justice.* Washington, DC: American Youth Policy Forum.

[illegible] Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2001.

[illegible] Rhode Island Training School for Youth, 2001.

[illegible] Teplin, L. (January 2001). *Assessing Alcohol, Drug, and Mental Disorders in Juvenile Detainees, OJJDP Fact Sheet.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[illegible] Rhode Island Department of Elementary and Secondary Education, Office of Special Education, 2001.

Children of Incarcerated Parents

DEFINITION

Children of incarcerated parents is the number of children with a parent in prison per 1,000 children. The data are reported by the place of the parent's last residence before entering prison.

SIGNIFICANCE

The number of children in the U.S. with parents in prison has grown from 936,500 in 1991 to 1.5 million in 1999. The number of imprisoned fathers increased 58% during that time, while the number of imprisoned mothers increased 98%.[4]

As a result of parental incarceration, and the crimes and arrests that often precede it, most children experience disruption in their homes, a series of temporary caregivers or placement in foster care, financial hardship, and lack of contact with their parents.[4] Children of incarcerated parents are at greater risk for many negative behaviors including poor academic achievement, substance abuse, and delinquency.[5] The majority of children with an incarcerated parent live in poverty before, during, and after their parent's incarceration.[6]

Despite the large and increasing numbers of incarcerated parents, the children they leave behind remain a hidden population and little attention is paid to their special needs. The corrections system does not formally recognize these children. Their care arrangements are often handled informally by family members, so they rarely come to the attention of a child welfare agency.[5] While the children may experience problems at school or in other aspects of their lives, these problems are often not recognized as being related to the incarceration of a parent.[6]

During the past twenty years, there has been a steady increase and change in the make-up of the prison population, due partly to stricter sentencing guidelines and mandatory sentences, particularly for drug-related offenses.[7] One in three mothers in state prison committed drug-related crimes. Mothers are more likely than fathers to report drug use in the month prior to their arrest.[8]

Seventy percent of imprisoned parents in the U.S. do not have a high school diploma. More than one-quarter of fathers and more than half of mothers were unemployed in the month before their arrests.[9] Upon release from prison, a successful transition to the community often requires ongoing substance abuse or mental health services, adequate housing, and assistance entering the job market.[10,11]

Incarcerated Parents in Rhode Island

◇ Of the 223 incarcerated women at the Rhode Island Department of Corrections (RIDOC) on February 18, 2002, 74% reported that they have children. Of the 3,190 incarcerated men, 46 % reported that they have children.

◇ From April 2001 to December 2001, 61 incarcerated mothers at the RIDOC Women's Division and their 101 children participated in a visitation program through Women in Transition. Children are permitted to come to the prison once a week to participate in a structured activity with their parents, have lunch, and spend some quiet time together. In September 2001, the RIDOC began a visitation program for fathers.

◇ To prepare incarcerated mothers to make a smooth transition back into the community once they are released, Women in Transition offers parenting classes, assistance in finding adequate housing and social services, and intensive case management and individualized parenting education through home visitation with clients.

Source: Rhode Island Department of Corrections, February 2002.

Incarcerated Parents and Their Children in the United States, 1999

◇ U.S. children of incarcerated fathers are three times more likely to be in the care of their other parent than children of incarcerated mothers. More than half (53%) of incarcerated mothers report that their children's grandparents are their caregivers, compared to 13% of incarcerated fathers. Ten percent of mothers and 2% of fathers in state prison report a child living in foster care.

◇ Seven percent of all Black children in the U.S. have an imprisoned parent, nearly nine times higher than the rate for White children, and Hispanic children are three times as likely as White children to have an imprisoned parent.

Source: Mumola, C. (August 2000). *Incarcerated Parents and their Children*. Washington, DC: U.S. Bureau of Justice Statistics.

Table 21

Children of Incarcerated Parents, Rhode Island, 2002

CITY/TOWN	# OF INCARCERATED PARENTS	# OF CHILDREN REPORTED*	2000 TOTAL POPULATION UNDER AGE 18	RATE PER 1,000 CHILDREN
Barrington	2	2	4,745	0.4
Bristol	3	8	4,399	1.8
Burrillville	10	14	4,043	3.5
Central Falls	60	125	5,531	22.6
Charlestown	5	10	1,712	5.8
Coventry	19	42	8,389	5.0
Cranston	69	138	17,098	8.1
Cumberland	7	10	7,690	1.3
East Greenwich	7	18	3,564	5.1
East Providence	53	121	10,546	11.5
Exeter	3	10	1,589	6.3
Foster	0	0	1,105	0.0
Glocester	3	6	2,664	2.3
Hopkinton	7	15	2,011	7.5
Jamestown	3	4	1,238	3.2
Johnston	37	81	5,906	13.7
Lincoln	11	18	5,157	3.5
Little Compton	0	0	780	0.0
Middletown	6	14	4,328	3.2
Narragansett	8	15	2,833	5.3
New Shoreham	1	3	185	NA
Newport	59	139	5,199	26.7
North Kingstown	15	45	6,848	6.6
North Providence	28	51	5,936	8.6
North Smithfield	4	12	2,379	5.0
Pawtucket	161	349	18,151	19.2
Portsmouth	9	20	4,329	4.6
Providence	632	1,415	45,277	31.3
Richmond	4	7	2,014	3.5
Scituate	7	14	2,635	5.3
Smithfield	5	9	4,019	2.2
South Kingstown	18	49	6,284	7.8
Tiverton	4	5	3,367	1.5
Warren	5	13	2,454	5.3
Warwick	65	124	18,780	6.6
West Greenwich	0	0	1,444	0.0
West Warwick	56	133	6,632	20.1
Westerly	23	46	5,406	8.5
Woonsocket	95	219	11,155	19.6
Unknown Residence	*130*	*294*	*NA*	*NA*
Core Cities	*1,007*	*2,247*	*85,313*	*26.3*
Remainder of State	*627*	*1,351*	*162,509*	*8.3*
Rhode Island	*1,634*	*3,598*	*247,822*	*14.5*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Corrections based on self-reports from the 3,190 male prisoners and 223 female prisoners at the correctional facility in Cranston, Rhode Island as of February 18, 2002.

*Data on the number of children are self-reported by the incarcerated parent and may include some children over age 18. Nationally and in Rhode Island, much of the existing research has relied on self-reporting by incarcerated parents or caregivers.

References for Indicator

[illegible] Mumola, C. (August 2000). *Incarcerated Parents and their Children.* Washington, DC: U.S. Bureau of Justice Statistics.

[illegible] Beatty, C. (1997). *Parents in Prison: Children in Crisis: An Issue Brief.* Washington, DC: Child Welfare League of America Press.

[illegible] Johnston, D. (1995). "The Care and Placement of Prisoner's Children" in K. Gabel and D. Johnston (Eds.), *Children of Incarcerated Parents* (pp. 103-123). New York, NY: Lexington Books.

[illegible] Seymour, C. (1998). "Children with Parents in Prison: Child Welfare Policy, Program, and Practice Issues" in *Child Welfare*, Vol. 77, #5, 469-491.

[illegible] Seymour, C. B. and Wright, L.E. (2000). *Working With Children and Families Separated By Incarceration: A Handbook for Child Welfare Agencies.* Washington, DC: CWLA Press.

[illegible] Conly, C. (December 1998). *The Women's Prison Association: Supporting Women Offenders and Their Families.* Washington, DC: U.S. Department of Justice, Office of Justice Programs.

Children Witnessing Domestic Violence

DEFINITION

Children witnessing domestic violence is the percentage of reported domestic violence incidents in which children under age 18 were present in the home. The data are based on police reports of domestic violence in 2000. Domestic violence is the use of physical force, or threat of force, against a current or former partner in an intimate relationship, resulting in fear and emotional and/or physical suffering.

SIGNIFICANCE

Domestic violence is a serious social issue that affects all communities and cuts across racial, ethnic and economic lines.[1] It is estimated that one-fifth to one-third of all women are assaulted by a partner or ex-partner during their lifetime.[2] In Rhode Island in 2000, police reports indicate that children were present in 39% (3,002) of domestic violence incidents reported.[3] National surveys of mothers indicate that 87% of children have witnessed the abuse in homes where there is domestic violence.[4]

Children are exposed to domestic violence in several ways. They may witness or hear violent events, become directly involved by trying to intervene, or experience the aftermath of violence by seeing their mother's emotional and physical injuries or damage done to their homes.[5] Children who are exposed to domestic violence are much more likely to be victims of child abuse and neglect. Both child maltreatment and domestic violence occur in an estimated 30 to 60 percent of families where there is some form of family violence.[6]

Exposure to domestic violence has an adverse impact across a range of child functioning.[7] Children who witness domestic violence are more likely to be aggressive and have behavior problems and are more prone to depression, anxiety, phobias and low self-esteem. Exposure to violence in the home impairs cognitive, academic and social functioning as well.[8] Although many children experience these negative effects as a result of exposure to domestic violence, some children emerge from the experience relatively unscathed. A child's age and temperament, the severity and frequency of the violence, and the availability of adults who can emotionally protect or sustain the child greatly affect the child's response.[9]

The effects of exposure to domestic violence can last into adulthood. For males, growing up in a violent home is the strongest predictor of becoming a batterer in the teen and adult years. Both men and women who grow up in violent homes are at increased risk for depression and other trauma-related symptoms.[10]

Services for Children Exposed to Domestic Violence

◇ Law enforcement responses to domestic violence have improved over the past decade. Rhode Island police officers use special reporting forms to document children's exposure to violence and, in many locations, receive training in ways to respond to children who witness domestic violence.[11]

◇ Successful school-based prevention programs develop anger management and conflict resolution skills and create a high level of trust so that children can disclose exposure to domestic violence and teachers can make referrals.[12]

◇ It is critical that child welfare caseworkers are trained to identify domestic violence in the home, assess the risks associated with the violence, and develop a safety plan that includes both the mother and child.[13]

◇ Mental health services for children exposed to domestic violence develop children's ability to cope with their emotional responses and reduce the symptoms they experience, promote positive behavior patterns, and help create a safe, stable, and nurturing family environment.[14]

◇ Rhode Island's statewide network of six shelters and advocacy programs provide services to victims of domestic violence, including shelter, advocacy, counseling and education. During 2001, 335 women and 442 children spent time in a domestic violence shelter.[15]

◇ Rhode Island's domestic violence agencies provided services to 896 children in 2001, including therapy, individual counseling, expressive arts therapy, and child care. The shelters also provide school-based domestic violence prevention programs.[16]

Children Witnessing Domestic Violence

Children and Domestic Violence in Rhode Island

◇ The number of domestic violence incidents reported to Rhode Island police increased from 6,541 in 1998 to 7,754 in 2000. The number of incidents with children present increased from 2,573 to 3,002 between 1998 and 2000.[17]

◇ Police officers reported that in 2,043 incidents the children saw their parent being abused and in 2,463 incidents the children heard (but did not see) their parent being abused. These numbers are based on police reports in which the attending officer may check any combination of three boxes: Were children present during the incident? Did children witness the incident? Did children hear the incident?[18]

◇ Table 22 underrepresents the number of incidents of domestic violence in which a child was present because police reports are not fully completed in all cases. Additionally, many cases of domestic violence are never reported to police.

◇ Table 22 underestimates the total number of children who experienced domestic violence in their homes, since more than one child may be present at an incident.

Table 22.

Domestic Violence Incidents with Children Present, Rhode Island, 2000

CITY/TOWN	TOTAL NUMBER OF DOMESTIC VIOLENCE INCIDENT REPORTS	TOTAL NUMBER OF INCIDENTS IN WHICH A CHILD WAS PRESENT	% OF INCIDENTS WITH CHILDREN PRESENT
Barrington	58	15	26%
Bristol	149	59	40%
Burrillville	81	32	40%
Central Falls	165	88	53%
Charlestown	38	18	47%
Coventry	218	92	42%
Cranston	366	134	37%
Cumberland	116	51	44%
East Greenwich	34	12	35%
East Providence	265	131	49%
Exeter	NA	NA	NA
Foster	13	5	38%
Glocester	71	22	31%
Hopkinton	41	22	54%
Jamestown	16	2	13%
Johnston	403	133	33%
Lincoln	84	39	46%
Little Compton	10	8	80%
Middletown	148	49	33%
Narragansett	91	31	34%
Newport	448	161	36%
New Shoreham	6	2	33%
North Kingstown	281	114	41%
North Providence	186	68	37%
North Smithfield	72	28	39%
Pawtucket	830	349	42%
Portsmouth	149	50	34%
Providence	1,270	436	34%
Richmond	10	6	60%
Scituate	33	17	52%
Smithfield	141	49	35%
South Kingstown	136	41	30%
Tiverton	96	33	34%
Warren	216	78	36%
Warwick	457	191	42%
Westerly	191	78	41%
West Greenwich	18	4	22%
West Warwick	295	128	43%
Woonsocket	478	195	41%
Rhode Island State Police	*74*	*31*	*42%*
Core Cities	*3,191*	*1,229*	*39%*
Remainder of State	*4,563*	*1,773*	*39%*
Rhode Island	*7,754*	*3,002*	*39%*

Source of Data for Table/Methodology

The number of domestic violence incident reports and the number of incidents in which children were present are based on the Domestic Violence and Sexual Assault/Child Molestation Reporting Forms received by the Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit between January 1, 2000 and December 31, 2000.

References for Indicator

[1] *The Impact of Domestic Violence on Children: A Report to the President of the American Bar Association* (1994). Chicago: American Bar Association Center for Children and the Law.

[2] Osofsky, J. (1995). "Children Who Witness Domestic Violence: the Invisible Victims." *Social Policy Report*. Society for Research in Child Development. Vol. IX, No. 3.

[3,16,18] Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit.

[4] Rhode Island Coalition Against Domestic Violence (1997). Children and Domestic Violence (Fact Sheet).

[5,8] Fantuzzo, J. and Mohr, W. (1999) "Prevalence and Effects of Child Exposure to Domestic Violence" in *The Future of Children: Domestic Violence and Children*, Vol. 9, No. 3 (Winter 1999). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[6,10] Children's Defense Fund (2000). *Domestic Violence and Its Impact on Children* [Internet].

[7,11] McAlister Groves, B. (1999) Mental Health Services for Children Who Witness Domestic Violence in *The Future of Children: Domestic Violence and Children*, Vol. 9, No. 3. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[9] "The Legal System's Response to Children Exposed to Domestic Violence" in *The Future of Children: Domestic Violence and Children*, Vol. 9, No. 3 (Winter 1999). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[12] "Domestic Violence and Children: Analysis and Recommendations" in *The Future of Children: Domestic Violence and Children*, Vol. 9, No. 3 (Winter 1999).

[13] "Child Protective Services and Domestic Violence" in *The Future of Children: Domestic Violence and Children*, Vol. 9, No. 3 (Winter 1999).

[14,15] The Rhode Island Coalition Against Domestic Violence. Data for period from January 1, 2001 to December 31, 2001.

Child Abuse and Neglect

DEFINITION

Child abuse and neglect is the total number of indicated investigations of child abuse and neglect per 1,000 children. Indicated investigation means that credible evidence exists that child abuse and/or neglect occurred following an investigation of an abuse report. An indicated investigation can involve more than one child and multiple allegations of different forms of abuse. Child abuse includes physical, sexual, and emotional abuse. Child neglect includes physical, emotional, educational and medical neglect.

SIGNIFICANCE

Preventing child abuse and neglect is critical to helping children grow into strong, healthy, productive adults and good parents. Children are at increased risk for maltreatment if their parents or caregivers are overwhelmed by multiple problems such as inadequate income, lack of a job or adequate housing, emotional stress, isolation from extended family or friends, drug and/or alcohol abuse, mental illness, or domestic violence.[1] Recent studies confirm that child abuse is linked to increases in poor school performance, juvenile delinquency, running away, substance abuse, suicide, criminal behavior, emotional disturbances, promiscuity, and teenage pregnancy.[2,3,4]

Many abusive parents lack essential parenting skills and are struggling with a combination of social and economic issues. Preventing child abuse and neglect requires adequate income supports, housing, food, and child care as well as parenting education and counseling for substance abuse, domestic violence, and other problems. Families benefit from access to community-based, comprehensive services that are able to flexibly respond to their needs.[5,6]

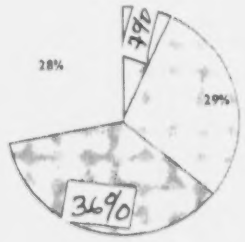
Responding to reports of child abuse and neglect and ensuring child safety in crisis situations are important functions of child protection systems. However, maintaining the capacity to focus on prevention is equally critical and frequently more cost-effective. Currently in Rhode Island a disproportionate share of the budget of the Department of Children, Youth and Families (DCYF) continues to be spent on high-end costs such as psychiatric hospitalization, juvenile corrections, and residential treatment. The absence of appropriate lower-cost placements contributes to this mismatch.[7,8]

In 2001 in Rhode Island there were 2,261 indicated cases of child abuse and neglect involving 3,079 children.[9] During 2000, there were 17 children hospitalized with the diagnosis of child abuse or neglect.[10]

Indicated Cases of Child Abuse and Neglect, Rhode Island, 2001

By Age of Victim

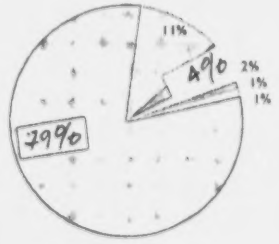
7%	Under Age 1
29%	Ages 1 to 5
36%	Ages 6 to 11
28%	Ages 12 and Older



*(n=3,079)**

By Relationship of Victim to Perpetrator

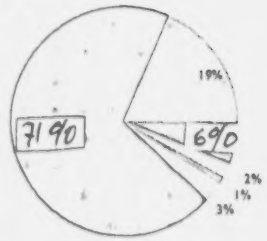
79%	Parents
11%	Relatives/Household Members
4%	Child Care Providers
2%	Foster Parents
1%	Residential Facility Staff
1%	Other or Unknown



*(n=3,916)****

By Type of Abuse

71%	Neglect
19%	Physical Abuse
6%	Sexual Abuse
2%	Medical Neglect
1%	Emotional Abuse
3%	Other



*(n=3,818)***

Notes on Pie Charts

All data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2001. Numbers may not add to 100 due to rounding.

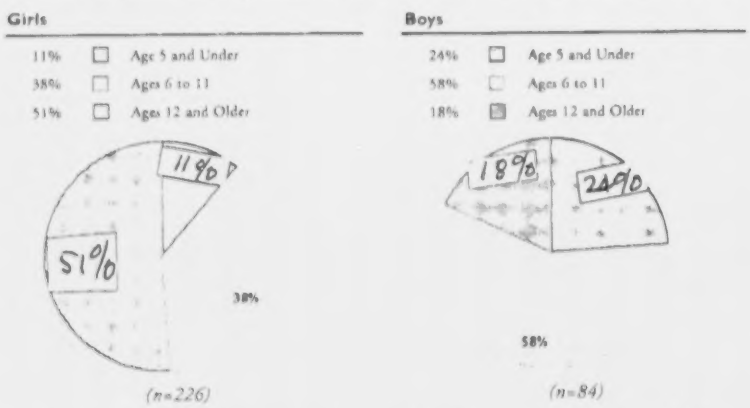
**These data reflect an unduplicated count of child victims. The number of victims is higher than the number of indicated cases. One indicated case can involve more than one child victim.*

***This number is greater than the unduplicated count of child victims because children often experience more than one maltreatment event and/or more than one type of abuse. Within each type of abuse, the number of child victims is unduplicated.*

****Perpetrators can abuse more than one child and can abuse a child more than once.*

BEST COPY AVAILABLE

Child Sexual Abuse, by Gender and Age of Victim, Rhode Island, 2001



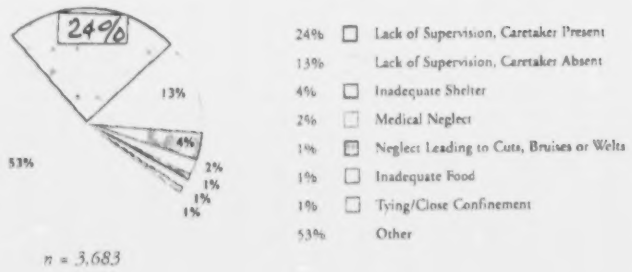
◇ In Rhode Island in 2001, there were 310 indicated allegations (confirmed claims) of sexual abuse involving 213 children. Some children were victims of sexual abuse more than once. An indicated allegation of abuse is defined as one in which credible evidence of sexual abuse was found.

◇ In 73% (226) of the 310 indicated allegations of sexual abuse the victim was a female. Of the instances of sexual abuse involving girls, more than half (51%) of the victims were ages 12 and over. Of the instances of sexual abuse involving boys, more than half (58%) of the victims were ages 6 to 11.

◇ The most frequent perpetrators of sexual abuse were birth parents (19%) and relative caretakers (19%), followed by baby sitters/caretakers (15%), and other household member caretakers (14%). There were four instances of sexual abuse by a foster parent and one instance of sexual abuse by a day care provider.

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2001.

Child Neglect, by Category of Neglect, Rhode Island, 2001



◇ In 2001, there were 3,683 indicated allegations of neglect in Rhode Island involving 2,762 children. Indicated allegations are confirmed claims with credible evidence of abuse or neglect. There may be multiple allegations involving multiple children within each investigation.

◇ The single largest categories of neglect involve inadequate supervision by a caretaker either while the caretaker was present or due to the caretaker's absence (leaving children alone).

◇ Over half (1,934) of all incidents of neglect involve a wide variety of other issues, including abandonment, educational neglect, failure to thrive, substance abuse by the child, infants born drug-addicted, emotional neglect, or excessive/inappropriate discipline.

◇ In Rhode Island in 2001, all 5 child deaths resulting from abuse or neglect were categorized as resulting from neglect. Families overwhelmed by multiple personal, social or economic problems may lack the resources to meet their children's needs and require a variety of readily accessible services and interventions.[11]

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2001.

Child Abuse and Neglect

Rhode Island Child Deaths Due to Child Abuse and/or Neglect*

YEAR	NUMBER OF DEATHS	YEAR	NUMBER OF DEATHS
1992	4	1997	2
1993	3	1998	3
1994	5	1999	3
1995	5	2000	3
1996	4	2001	5
Total 1992-1996	*21*	*Total 1997-2001*	*16*

◇ Between 1992 and 2001 in Rhode Island, 37 children died as a result of injuries due to abuse or neglect.

**Based on R.I. Department of Children Youth and Families determination of death due to child abuse or neglect by a parent or caretaker.*

Child Abuse and Neglect in Rhode Island Communities, 1995 and 2000

Town	1995	2000
Woonsocket	19.8	18.9
West Warwick	14.6	14.7
Central Falls	19.7	13.8
Newport	13.0	11.3
Pawtucket	12.9	10.8
Providence	14.4	10.6
Warren	11.6	10.4
Westerly	10.7	8.9
Rhode Island	*9.6*	*8.1*

◇ Since the mid-90s, eight Rhode Island communities have had child abuse and neglect rates that exceed the state rate. These eight communities account for nearly two-thirds of the indicated cases of child abuse and neglect in Rhode Island.

◇ Since 1995, the child abuse and neglect rate in Central Falls has decreased by nearly one-third, from 19.7 cases per 1,000 children in 1995 to 13.8 cases per 1,000 children in 2000.

Source: Rhode Island Department of Children, Youth and Families. Data reported as 1995 are an average of 1994, 1995, and 1996. The denominator is from the 1990 census. Data reported as 2000 are an average of 1999, 2000, and 2001. The denominator is from the 2000 census.

Community Child Protection: A Collaborative Approach

Child protection services in many states find their capacity overwhelmed by the increasing rates of reported child abuse and the increasing complexity and severity of family problems, especially substance abuse. In response, some states are experimenting with a community-centered approach to child protection and child abuse/neglect prevention. Community child protection initiatives often focus on communities with high poverty rates and include the following components:

Prevention

A well-coordinated system of supports and services for families is needed in order to prevent maltreatment and its recurrence. Children are at increased risk of abuse and neglect when parents have multiple social and economic problems. The most effective systems also identify maltreatment, have systems to hold perpetrators accountable, and provide treatment for victims of abuse.

Shared Responsibility and Collaboration

Given the magnitude of the child abuse and neglect problem, it is important for the child protection agency to work with community partners. A cooperative network of public and private agencies, service providers and individuals can lead to shared responsibility and improved services. Cross-training, one-stop service centers, and multidisciplinary teams of professionals help to support effective collaboration.

Individualized Responses

Effective services are coordinated based on individualized family needs and draw on family strengths. To the extent safe and possible, family participation in service planning is encouraged and family relationships are preserved even if it is necessary to remove the child from the home, either temporarily or permanently.

Sources: *We Are in This Together, Community Child Protection* (1998). New York, NY: Edna McConnell Clark Foundation; and "Community Collaboration: A Growing Promise in Child Welfare" in *Best Practice/Next Practice*. Vol. 1, No. 2 (Fall 2000). Washington, DC: National Child Welfare Resource Center for Family Centered Practice. A Service of the Children's Bureau, U.S. Department of Health and Human Services.

Table 23

Indicated Investigations of Child Abuse and Neglect, Rhode Island, 2001

CITY/TOWN	TOTAL POPULATION OF CHILDREN UNDER AGE 21	NUMBER OF INDICATED CASES OF CHILD ABUSE/NEGLECT	2001 RATE OF CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN
Barrington	5,211	10	1.9
Bristol	6,294	15	2.4
Burrillville	4,646	35	7.5
Central Falls	6,443	89	13.8
Charlestown	1,952	16	8.2
Coventry	9,438	40	4.2
Cranston	19,854	109	5.5
Cumberland	8,595	33	3.8
East Greenwich	3,861	18	4.7
East Providence	12,060	68	5.6
Exeter	1,790	12	6.7
Foster	1,234	6	4.9
Glocester	2,998	10	3.3
Hopkinton	2,255	14	6.2
Jamestown	1,354	4	3.0
Johnston	6,729	36	5.3
Lincoln	5,720	24	4.2
Little Compton	874	2	2.3
Middletown	4,757	19	4.0
Narragansett	3,897	6	1.5
New Shoreham	203	2	9.9
Newport	7,046	87	12.3
North Kingstown	7,561	39	5.2
North Providence	6,854	54	7.9
North Smithfield	2,674	12	4.5
Pawtucket	20,870	221	10.6
Portsmouth	4,726	12	2.5
Providence	62,125	595	9.6
Richmond	2,221	6	2.7
Scituate	2,944	8	2.7
Smithfield	6,112	15	2.5
South Kingstown	10,393	24	2.4
Tiverton	3,806	17	4.5
Warren	2,809	28	10.0
Warwick	21,330	119	5.6
West Greenwich	1,606	5	3.1
West Warwick	7,746	98	12.7
Westerly	6,094	45	7.4
Woonsocket	12,792	240	18.8
Out of State/Unknown	*NA*	*68*	*NA*
Core Cities	*109,276*	*1,232*	*11.3*
Remainder of State	*190,598*	*1,029*	*5.4*
Rhode Island	*299,874*	*2,261*	*7.5*

Source of Data for Table/Methodology

Data are from the RI Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), number of indicated cases (indicated investigations) for the period January 1, 2001 to December 31, 2001.

An indicated investigation is an investigated report of child abuse and neglect for which credible evidence exists that child abuse and/or neglect occurred. An indicated investigation can involve more than one child and multiple allegations.

The denominator is the number of children under the age of 21 according to Census 2000.

References for Indicator

[1,2,3] *America's Children at Risk: A National Agenda for Legal Action* (1993). Chicago, IL: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[4,5,6] "Protecting Children from Abuse and Neglect" in *The Future of Children*, Vol. 8, No. 1 (Spring, 1998). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[4] English, D. (1998). "The Extent and Consequences of Child Maltreatment" in *The Future of Children*, Vol. 8, No. 1 (Spring, 1998). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[7] D'Ambra, L. (September 2001). *DCYF System of Care Task Force Report of the Current Reality Subcommittee*. Providence, RI: Office of the Child Advocate.

[8] *A Review of the Rhode Island Department of Children, Youth and Families* (January 2001). Providence, RI: Rhode Island Public Expenditure Council.

[9] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2001.

[10] Rhode Island Department of Health, Hospital Discharge Database, FY 2000.

Children in Out-of-Home Placement

DEFINITION

Children in out-of-home placement is the number of children who have been removed from their families and are in the care of the Rhode Island Department of Children, Youth and Families (DCYF) while awaiting permanent placement. Out-of-home placements include foster homes, placement with a relative or friend, group homes, shelter care, residential treatment, and medical facilities. Permanent placement includes reunification with the family, adoption or guardianship.

SIGNIFICANCE

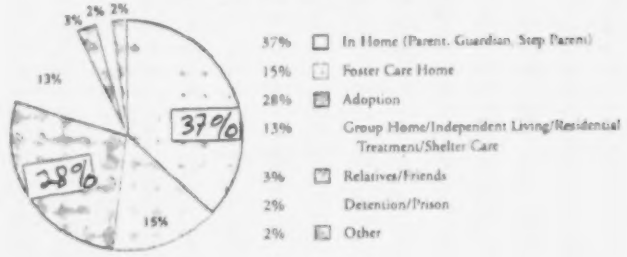
Children need stability, permanency and safety in order to develop and flourish. Removal from the home may be necessary for the child's safety and well-being; however, it can be disruptive and traumatic for both the child and the family.[1] Children who have been abused or neglected are particularly vulnerable and in need of a safe, stable and permanent environment which provides for their well-being. Yet children in out-of-home care frequently remain in temporary placements for extended periods of time, experience multiple placements, lose contact with family members, friends and neighborhoods, and may experience recurrence of abuse.[2] Older children may linger in care until adulthood.

Long-term stays in temporary out-of-home placement can negatively affect children, causing emotional, behavioral or educational problems that adversely affect their future well-being.[3]

The goal of the federal Adoption and Safe Families Act of 1997 (ASFA) is to ensure that out-of-home placement is stable, safe, and leads to a permanent placement (such as reunification, adoption or guardianship) as quickly as possible without jeopardizing safety. States are now required to track how long children remain in out-of-home placement, how many placements they experience, how frequently they are re-abused and where they go after leaving state custody.[4,5] Nationally, these child welfare objectives continue to be challenged by insufficient staff, heavy caseloads, and inadequate and fragmented resources for foster care, mental health, substance abuse, child care and housing.[6]

On December 31, 2001 there were 2,499 Rhode Island children in out-of-home placement, a rate of 9.8 children in state custody for every 1,000 children under age 21.[7,8]

Children in DCYF Care by Living Arrangement, Rhode Island, December 2001



◇ As of December 31, 2001, just under one-third (31%) of the 8,153 children in the DCYF caseload were in out-of-home placement (foster homes, placement with a relative or friend, group home, shelter care, residential treatment, and medical facilities). There were 2,499 Rhode Island children under age 21 in the care of DCYF in out-of-home placements.

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2001.

Night-to-Night Placements

◇ Night-to-night placements refer to the temporary nightly placement of youth under the care of DCYF who are awaiting longer-term placements.

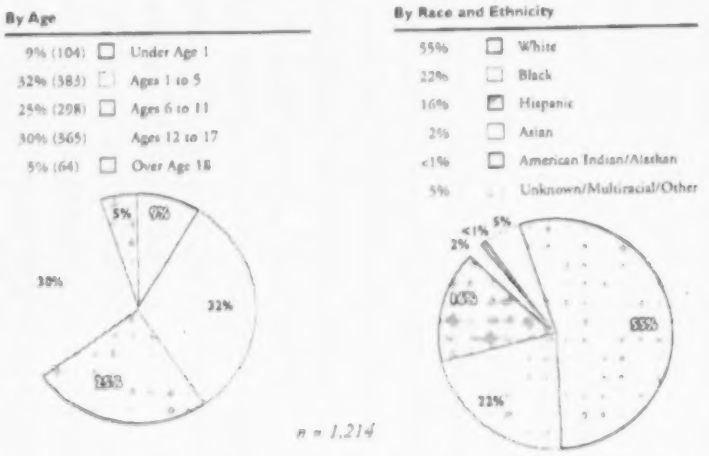
◇ As a result of court action in 2001 by the Office of the Child Advocate, a court order now reaffirms the principle that night-to-night placements are unacceptable, except in rare emergencies. Any children who are in night-to-night placement must now be transported to school. DCYF also agreed to expand capacity of temporary placement beds, especially for adolescents, and to make additional efforts to recruit foster parents for adolescents.[9]

◇ Prior to court action there was an average of 93 children per month in night-to-night placements. This dropped to 22 children per month in the six months after the court agreement. In January 2002, the average number of children in night-to-night placement was 48.[10]

BEST COPY AVAILABLE

Children in Foster Care Homes, Rhode Island, 2002

As of January 2, 2002, there were 1,214 children in foster care homes. Of these, 564 (46%) were in non-relative foster homes, 518 (43%) were in relative foster homes, and 132 (11%) were in the care of private agencies. There were 570 licensed foster care homes, 162 licensed relative foster care homes, and 204 private agency homes. An additional 198 non-relative home and 200 relative home licenses were pending. As of 2001, relative homes are licensed under the same criteria as non-relative homes.



Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), January 2002.

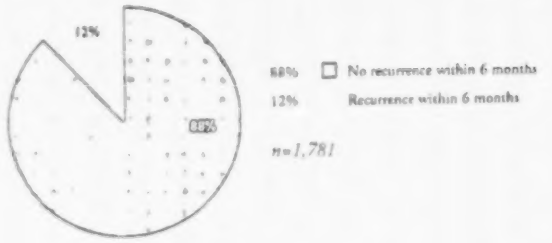
◇ Child abuse and neglect happens to children of all races and economic classes. But national data indicate that poor families and families of color are more likely to be identified by the child welfare system and are more likely to have their children removed and placed in foster care; once in foster care, children of color are more likely to remain there for long periods of time, and to experience multiple placements.[11]

Child safety, permanency and well-being are recognized as the broad goals of child protection systems under the Adoption and Safe Families Act.

ENSURING THE SAFETY OF CHILDREN IN OUT-OF-HOME PLACEMENT

The safety of all children who come to the attention of a child protection agency is a priority in any decision regarding removal from the home, placement, and permanency planning. Protecting children from abuse or neglect while in state custody is also a paramount concern.

Recurrence of Maltreatment, Rhode Island, 1999



◇ Of the 1,781 Rhode Island children who were victims of abuse or neglect during the first six months of 1999 (whether or not they were removed from the home), 12% experienced one or more recurrences of abuse or neglect within 6 months.

◇ Of the 3,292 children who were in out-of-home placements between January and September 1999 in Rhode Island, 2.3% (76) were maltreated by a foster parent or facility staff.

Source: *Child Welfare Outcomes 1999: Annual Reports* (2001). U.S. Department of Health and Human Services. Detailed Case Data Component (DCDC) of the National Child Abuse and Neglect Data System (NCANDS), 1999.

BEST COPY AVAILABLE

Children in Out-of-Home Placement

PERMANENCY FOR CHILDREN IN OUT-OF-HOME PLACEMENT

A child welfare system's effectiveness in achieving permanency for children in out-of-home placement includes three interrelated measures: the timeliness and lasting effect of a permanent placement; the stability of temporary placements; and the proportion of successful permanent placements.[12]

Length of Time to Reunification or Adoption, Rhode Island, FY1999*

	Reunification	Adoption
Less than 12 months	64%	10%
12-23 months	17%	20%
24-35 months	4%	27%
36-47 months	1%	12%
48 months or more	2%	15%
Missing	11%	17%
Total Number	*638*	*211*

* Because of federal requirements and guidelines governing the collection of data about children in out-of-home placement, Fiscal Year (FY) throughout this indicator refers to the federal fiscal year (October 1- September 30).

◇ Of the 638 children reunified with their parents in FY1999, 64% had been in DCYF care for less than 12 months and 17% had been in DCYF care 12 to 23 months. Of the 211 children adopted in FY1999, 30% had been in DCYF care less than 24 months.

◇ The data currently collected by states for federal reporting purposes focuses on duration in placement for children exiting care to adoption or reunification. For children who do not exit out-of-home placement in a given year the length of time in temporary placements is also a concern.

◇ To ensure that pressure to speed up reunification is not affecting recurrence of maltreatment or other breakdowns in placement, success in reducing the duration in temporary placement must be measured in conjunction with rates of re-entry into the system. In FY1999, at least 30% of children in Rhode Island who entered out-of-home placement were re-entering after a prior episode.

Source: *Child Welfare Outcomes 1999: Annual Report* (2001) U.S. Department of Health and Human Services. AFCARS Annual Foster Care Database, FY 1999.

Placement Stability for Children in Out-of-Home Placement

◇ In FY1999, 23% (360) of children who had been in out-of-home care for less than one year had experienced 3 or more placements, down from 27% in FY1998. Three or more placements were experienced by 38% of children who had been in care between 12 and 23 months, and 53% of children who had been in care for 24-35 months.[13]

Number of Permanent Placements Achieved in Rhode Island, FY1999

Children Who Exited Foster Care in FY1999

	All Children	Children With Disability	Children Who Were Age 12 or More at Entry
Adoption	21%	30%	<1%
Guardianship	2%	1%	1%
Reunification with Parents	63%	40%	68%
Other	9%	19%	18%
Missing	6%	11%	13%
Total Number	*1,018*	*182*	*319*

◇ The 1,018 Rhode Island children who exited care were a third of the 3,505 children in out-of-home placements in FY1999. Of the 1,018 children who exited care, 865 (or 85%) exited to a permanent placement such as adoption, guardianship or reunification with their parents.

◇ Those who do not exit care may eventually age out never having found a permanent placement. In FY1999, 43 Rhode Island children exited out-of-home placements to emancipation. Of these, 84% were older than age 12 at entry into care.

◇ Youth who spend their teens in foster care suffer disproportionately from homelessness, unemployment, academic failure, incarceration and premature parenting. Federal funding through the John H. Chafee Foster Care Independence Program is now available for Independent Living programs that help prepare foster care youth for transition to adulthood.[14,15]

Source: *Child Welfare Outcomes 1999: Annual Report* (2001). U.S. Department of Health and Human Services. AFCARS Annual Foster Care Database, FY 1999.

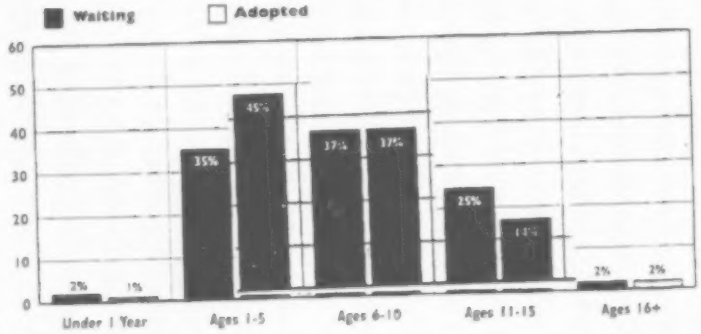
Well-being for Children in Out-of-Home Placement

While specific indicators for measuring safety and permanency have been developed and implemented, the U.S. Department of Health and Human Services is still in the process of defining similar indicators of well-being. It is expected that, at a minimum, these will include the receipt of appropriate health and education services by children in out-of-home placements.[16]

◇ Children in out-of-home care suffer more frequent and more serious medical, developmental, and psychological problems than nearly any other group of children including homeless children.[17] Nearly 95% have at least one physical health problem, and psychological and behavioral problems are prevalent.[18]

◇ Effective strategies to promote the optimal development of children in out-of-home placements include assessment of the child's needs at system entry; a process to address identified physical, mental, emotional, behavioral health and educational needs immediately; monitoring mechanisms to ensure services are provided; access to quality early care and education experiences; and court oversight of service provision as part of permanency planning.[19]

Children Waiting to Be Adopted (as of 9/30/99) and Children Adopted in FY1999, Rhode Island



Source: *Child Welfare Outcomes 1999: Annual Report* (2001). U.S. Department of Health and Human Services. AFCARS Annual Adoption and Foster Care Database: FY 1999.

◇ On 9/30/99, there were 339 Rhode Island children in the care of DCYF who were awaiting adoption. Of these, 2% were under age 1, 35% were ages 1 to 5, 37% were ages 6 to 10 and 27% were ages 11 and older.

◇ During FY1999, 292 Rhode Island children in the care of DCYF were adopted. Of these, 84% were under age 11.

Adoptions of Children in DCYF Care, 2001

◇ In calendar year 2001, there were 253 adoptions of children in the care of DCYF in Rhode Island.

◇ As of December 31, 2001, there were 201 children in the care of Rhode Island DCYF waiting to be adopted.

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2001

References

[1] "Protecting Children from Abuse and Neglect" in *The Future of Children, Vol. 8, No.1* (Spring, 1998). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[2] [3] *Child Welfare Outcomes 1998: Annual Report* (2000). Washington, DC: U.S. Department of Health and Human Services.

[4] Lovejoy, Anna (October 2000). *A Place to Call Home: State Efforts to Increase Adoptions and Improve Foster Care Placements*. Washington, DC: National Governor's Association Center for Best Practices.

[5] *Foster Care: States' Early Experiences Implementing the Adoption and Safe Families Act* (December 1999). Washington, DC: United States General Accounting Office.

[6] Malm, K. et al. (October 2001). *Running to Keep in Place: The Continuing Evolution of Our Nation's Child Welfare System*. Washington, DC: The Urban Institute.

[7] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST). 2001.

[8] U.S. Bureau of the Census, 2000 Census of Population (Rhode Island Children under age 18).

[9] Rhode Island Office of the Child Advocate, 2001.

[10] *America's Children at Risk: A National Agenda for Legal Action* (1993). Chicago, IL: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[11] *Child Welfare Outcomes 1999: Annual Report* (2001). Washington, DC: U.S. Department of Health and Human Services.

[12] Mendel, D. "Fostered or Forgotten?" in *ADVOCASEY*, Vol. 3, Number 2 (Fall 2001). Baltimore, MD: The Annie E. Casey Foundation.

[13] *Frequently Asked Questions about the Foster Care Independence Act of 1999 and the John H. Chafee Foster Care Independence Program* (February 2000). Seattle, WA: Children's Defense Fund, Child Welfare League of America, and National Association of Child Advocates.

[14] Barnitelli, E.S. (1998). *The Health Care of Children in Out-of-Home Care*. Washington, DC: CWLA Press.

[15] Risley-Curtiss, C. et al. (2001). *Health Care Policies for Children in Out-of-Home Care in Child Welfare*. Vol. LXXX, Number 3 (May/June 2001). Washington, DC: Child Welfare League of America.

[16] Dicker, S. et al. (2001). *Improving the Odds for the Healthy Development of Young Children in Foster Care*. New York, NY: National Center for Children in Poverty.

Education

Where Go the Boats?

by Robert Louis Stevenson

Dark brown is the river,
Golden is the sand.
It flows along for ever,
With trees on either hand.

Green leaves a-floating,
Castles of the foam,
Boats of mine a-boating—
Where will all come home?

On goes the river,
And out past the mill,
Away down the valley,
Away down the hill.

Away down the river,
A hundred miles or more,
Other little children
Shall bring my boats ashore.

BEST COPY AVAILABLE

184

183

Infant and Pre-School Child Care

DEFINITION

Infant and pre-school child care is the number of regulated child care slots per 100 children under age 6. Regulated child care slots include full-time licensed child care center slots and certified family child care home slots.

SIGNIFICANCE

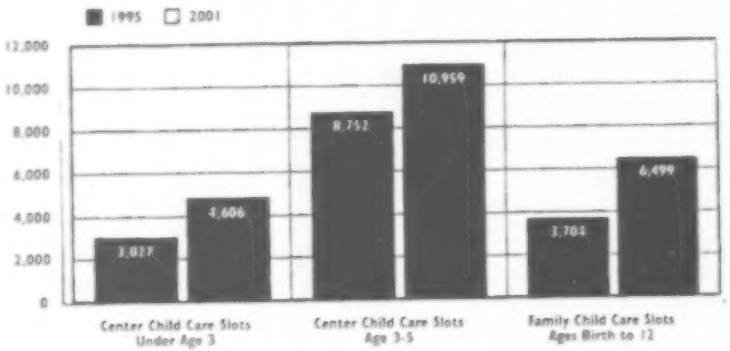
In keeping with national trends, child care has become a fundamental need for Rhode Island families over the past two decades. In Rhode Island in 1999, 69% of mothers with children under the age of six were in the labor force.[1] More than 53,000 Rhode Island infants and children under the age of 6 are in some form of child care (including relative care) because their mothers are in the labor force.[2]

High quality child care provides a safe and nurturing learning environment for infants and young children. Brain research indicates that early care and education has long-lasting effects on how children learn and develop, cope with stress, and handle their emotions.[3,4,5] Well-designed child care programs can promote the healthy cognitive, emotional and social development that is linked to school readiness. Children from all backgrounds who have received high quality child care score higher on tests of both cognitive and social skills in their early school years than children in poor quality care.[6,7]

Low-income children who participate in high quality early education programs score significantly higher on reading and math tests from the early grades through middle adolescence and are less likely to repeat a grade. They are more interested in learning, and are stronger in reading, math, thinking, problem-solving and working with others.[8,9] Low-income children, however, are less likely to be in high quality care arrangements because of the high cost of such care and because nonstandard work hours (weekends, night shifts, irregular hours) may make it difficult to find such care.[10,11,12,13]

In 2001 in Rhode Island, there were 22,064 slots for infants and preschool children in licensed child care centers or in certified family child care homes, as compared with 15,483 slots in 1995. In 2001 in Rhode Island, 26 of the 261 licensed child care centers were accredited by the National Association for the Education of Young Children and 17 of the 1,061 certified family child care homes were accredited by the National Association for Family Child Care.[14]

Infant and Pre-School Licensed Child Care Capacity, Rhode Island, 1995 and 2001



Source: Options for Working Parents, 1995 and 2001.

Quality in Child Care

◇ Responsive caregivers who surround children with language, warmth and chances to learn are the key to good child outcomes.[15] Lower child:staff ratios, smaller group sizes and better-educated teachers provide better quality overall, including more positive caregiving and a more developmentally-appropriate learning environment.[16,17,18]

◇ Higher quality child care is more expensive, primarily due to higher labor costs. High quality care is especially important for lower-income families whose children are often most at risk and likely to benefit most from higher quality child care.[19,20] Rhode Island's child care subsidy, which is guaranteed for families up to 225% of poverty and which is set at the 75th percentile of the market rate, is intended to ensure that quality child care is available to lower-income families.[21]

Table 24

Child Care for Children Under Age 6, Rhode Island, 2001

CITY/TOWN	# CHILD CARE CENTER SLOTS < AGE 3	# CHILD CARE CENTER SLOTS AGES 3-5	# CERTIFIED FAMILY CHILD CARE HOME SLOTS*	TOTAL REGULATED CHILD CARE SLOTS FOR CHILDREN < AGE 6	POTENTIAL CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE	SLOTS PER 100 CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE
Barrington	96	211	44	351	306	115
Bristol	53	74	98	225	507	44
Burrillville	16	78	78	172	370	47
Central Falls	39	137	165	341	705	48
Charlestown	0	0	32	32	154	21
Coventry	81	193	189	463	817	57
Cranston	354	736	402	1,492	1,461	102
Cumberland	57	125	231	413	740	56
East Greenwich	194	310	36	540	199	271
East Providence	322	569	144	1,035	1,099	94
Exeter	0	56	31	87	137	63
Foster	31	35	5	71	72	98
Glocester	16	66	38	120	239	50
Hopkinton	0	0	28	28	177	16
Jamestown	31	33	18	82	70	117
Johnston	105	350	127	582	506	115
Lincoln	208	258	50	516	443	116
Little Compton	0	0	0	0	72	0
Middletown	124	320	11	455	396	115
Narragansett	41	90	29	160	257	62
New Shoreham	0	0	0	0	26	0
Newport	126	174	42	342	577	59
North Kingstown	121	306	106	533	651	82
North Providence	67	193	154	414	522	79
North Smithfield	0	0	52	52	211	25
Pawtucket	297	705	474	1,476	2,271	65
Portsmouth	82	126	49	257	376	68
Providence	876	2,249	2,878	6,003	5,428	111
Richmond	0	37	54	91	207	44
Scituate	47	92	5	144	252	57
Smithfield	160	365	51	576	309	187
South Kingstown	104	198	110	412	541	76
Tiverton	25	145	46	216	279	77
Warren	25	152	46	223	251	89
Warwick	466	1167	349	1982	1549	128
West Greenwich	51	87	0	178	140	128
West Warwick	134	382	108	624	669	93
Westerly	72	387	18	297	534	56
Woonsocket	165	553	201	899	1317	68
Core Cities	*1,483*	*3,818*	*3,760*	*9,061*	*10,299*	*88*
Remainder of State	*3,123*	*7,141*	*2,759*	*14,538*	*15,158*	*89*
Rhode Island	*4,606*	*10,959*	*6,499*	*22,064*	*24,857*	*89*

*Family child care home slots are for children 5 — or 12 years old.

Source of Data for Table/Methodology

The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December 2001. Child care center slots are from Options for Working Parents, December 2001, Providence, RI: Providence Chamber of Commerce. See methodology on page 123 for calculation of denominator, potential number of children in need of regulated care.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References

U.S. Bureau of the Census, Current Population Survey, 1997-2001 average.

U.S. Bureau of the Census, 2000 Census of Population.

Shore, R. (1997). *Rethinking the Brain*. New York, NY: Families and Work Institute.

From Neurons to Neighborhood: The Science of Early Childhood Development (2000). Washington, DC: National Academy Press.

Using Mental Health Strategies to Move the Early Childhood Agenda and Promote School Readiness (2002). New York, NY: Carnegie Corporation of New York and National Center for Children in Poverty.

The Children of the Cost, Quality, and Outcomes Study Go to School (June 1999). Chapel Hill, NC: The University of North Carolina at Chapel Hill.

Vandell, D. Lowe and Wolfe, B. (2000). *Child Care Quality: Does It Matter and Does It Need to be Improved?* Madison, WI: Institute for Research on Poverty, University of Wisconsin at Madison.

Early Learning, Later Success: The Abecedarian Study, Executive Summary (1999). Chapel Hill, NC: Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

Xiang, Z. et al. (January 2002). *Effects Five Years Later: The Michigan School Readiness Program Evaluation Through Age 10*. Ypsilanti, MI: For the Michigan State Board of Education.

references continued on page 124

Children Enrolled in Head Start

DEFINITION

Children enrolled in Head Start is the percentage of eligible 3 and 4 year old children enrolled in the Head Start preschool program as of October 1, 2001.

SIGNIFICANCE

Head Start is a comprehensive early childhood program for low-income preschool children and their families. The program seeks to promote the healthy development of children in low-income families and help their parents achieve self-sufficiency. Most children in the program attend for one year and are four years old.[1] Children are eligible for Head Start if their family's income is below 100% of the federal poverty line; the family receives SSI or is enrolled in the Family Independence Program; or the family is using supportive services that are federal TANF benefits, such as transportation vouchers, subsidized child care, or job training. Children in foster care are also Head Start eligible. Up to 10% of the children served by Head Start can be in families that do not meet these eligibility guidelines, especially if the child has a special need.[2,3]

The Head Start program is designed to provide low-income children with the socialization and school-readiness skills they need to enter public schools on an equal footing with more economically advantaged children. Head Start performance standards require that programs deliver a high-quality early childhood education program; involve parents in program policy and planning; provide at least one nutritional meal per day; identify children's individual nutritional needs; ensure that each child has an ongoing source of health care; perform or obtain health, developmental and behavioral screenings; and make arrangements for mental health professionals to be available to identify mental health concerns and help locate needed treatment.[4]

Studies show that children in poor families are at greater risk for developmental delays and learning disabilities; have a greater prevalence of health and nutrition problems; and are more likely to have serious accidents, require special education, perform below grade level at school, drop out of school and earn less as adults.[5] Comprehensive programs that focus both on child development and family development are most effective in supporting vulnerable families and children.[6]

Head Start Outcomes

◇ Recent studies of the Head Start program indicate that it succeeds in narrowing the gap between disadvantaged children and other children, particularly in vocabulary, writing, math skills, and social skills, with the greatest gains among the most disadvantaged children. Children whose first language is not English also showed gains in school readiness and knowledge of English.[7]

◇ Head Start children continue to show improvements relative to other children during the early school grades, particularly when school transition services are provided.[8]

Comprehensive Child Care Networks

◇ Recognizing that Head Start is available to fewer than half of Rhode Island's lowest income children, resources were appropriated under Starting Right (Rhode Island's 1998 child care law) to create Comprehensive Child Care Networks in underserved communities.[9]

◇ Comprehensive Child Care Networks are modeled on Head Start and provide a developmentally-appropriate education program; transition assistance among programs and schools; health services; mental health services; support for children with disabilities; nutrition services; family education and empowerment; and services that expand community linkages and partnerships. Comprehensive Child Care Networks must be certified by the Rhode Island Department of Human Services.[10]

◇ In 2001, four Comprehensive Child Care Networks began providing services to children from Providence, East Providence, Warwick, North Kingstown, Pawtucket, Bristol-Warren, Barrington, Lincoln, and Cranston. On October 1, 2001, 151 children were receiving services. The program is funded to serve 450 children and is expected to reach capacity by the end of 2002. Children in the lowest-income families are prioritized for services to ensure that the most disadvantaged children receive the services they need to start school ready to learn.[11,12]

Table 25

Eligible Children Ages 3 and 4 Enrolled in Head Start, Rhode Island, 2001

CITY/TOWN	ESTIMATED ELIGIBLE CHILDREN AGED 3&4	NUMBER OF CHILDREN ENROLLED IN HEAD START	% OF ELIGIBLE 3&4 YEAR OLDS ENROLLED
Barrington	5	2	40%
Bristol	35	16	46%
Burrillville	26	24	92%
Central Falls	283	51	18%
Charlestown	12	6	50%
Coventry	63	53	84%
Cranston	206	211	100%
Cumberland	40	3	8%
East Greenwich	13	2	15%
East Providence	160	117	73%
Exeter	7	3	43%
Foster	3	1	33%
Glocester	9	5	56%
Hopkinton	18	10	56%
Jamestown	3	0	0%
Johnston	72	35	49%
Lincoln	30	4	13%
Little Compton	1	2	100%
Middletown	26	33	100%
Narragansett	27	4	15%
Newport	194	154	79%
New Shoreham	2	0	0%
North Kingstown	56	32	57%
North Providence	92	51	55%
North Smithfield	6	2	33%
Pawtucket	589	133	23%
Portsmouth	11	12	100%
Providence	2,386	914	38%
Richmond	9	3	33%
Scituate	11	4	36%
Smithfield	11	11	100%
South Kingstown	28	23	82%
Tiverton	17	28	100%
Warren	32	15	47%
Warwick	203	159	78%
Westerly	62	55	89%
West Greenwich	3	1	33%
West Warwick	145	119	82%
Woonsocket	395	240	61%
Core Cities	*3,847*	*1,492*	*39%*
Remainder of State	*1,444*	*1,046*	*72%*
Rhode Island	*5,291*	*2,538*	*48%*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, children enrolled on October 1, 2001, U.S. Department of Health and Human Services, Region 1, Administration on Children, Youth and Families; and Rhode Island Department of Human Services INRHODES Database, December 1, 1996-1998. The denominator is the estimated number of eligible children. See methodology on page 123.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[i] "The Future of Children: Long-Term Outcomes of Early Childhood Programs." (1995). *Head Start.* Vol. 5, No. 3. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[ii] Administration for Children and Families. *Program Instruction: Receipt of Public Assistance and Determining Eligibility for Head Start.*

[iii] Administration for Children and Families. *Head Start Program Regulations and Program Guidance* (45 CFR 1304, 1305).

[iv] Sherman, A (1997) *Poverty Matters: The Cost of Child Poverty in America.* Washington, DC: The Children's Defense Fund.

[v] *The Statement of the Advisory Committee on Services for Families with Infants and Toddlers* (1994). Washington, DC: Department of Health and Human Services.

[vi] *Head Start FACES: Longitudinal Findings on Program Performance (Third Progress Report)* (January 2001). Washington, DC: U.S. Department of Health and Human Services.

[vii] Ramey, S. et al. (2000). *Head Start Children's Entry into Public School: A Report on the National Head Start/Public School Early Childhood Transition Demonstration Study.* Birmingham, AL: Civitan International Research Center, The University of Alabama at Birmingham.

[viii] State of Rhode Island, Article 11 Relating to the Starting Right Initiative, Section 42-12-26.

[ix] *Certification Standards for Comprehensive Child Care Services Networks* (December 1999). Providence, RI: Rhode Island Department of Human Services, Center for Children and Families, Office of Child Care.

[x] Rhode Island Department of Human Services, October 1, 2001.

[xi] Comprehensive Child Care Services Program (8/2/01). Cranston, RI: Rhode Island Department of Human Services, Office of Child Care.

School-Age Child Care

DEFINITION

School-age child care is the number of licensed child care programs and slots for children ages 5 to 12. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 5 to 12 that do not require licensing by the state.

SIGNIFICANCE

Many parents need care for their school-age children during work hours. Children spend only 20% of their waking hours in school. The gap between parents' work schedules and students' school schedules can amount to 20 or more hours per week.[1] Many children are alone during the hours before and after school. It is estimated that nationally 8 million children ages 5 to 14 spend time without adult supervision on a regular basis.[2] As children get older they are much more likely to care for themselves when not in school. Nationally, while 10% of 6 to 9 year-olds regularly spend time in self-care when not in school, 35% of 10 and 11 year-olds, and 44% of 12 year-olds regularly care for themselves after-school.[3]

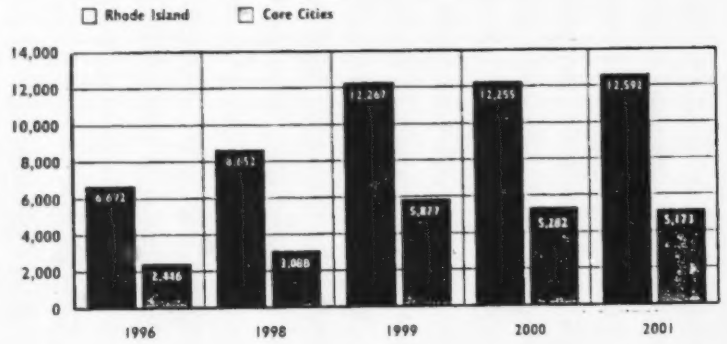
Children who are without adult supervision when school is out are at significantly greater risk of truancy from school, emotional stress, receiving poor grades, substance use, sexual activity, and crime.[4,5] Juvenile crime peaks between the hours of 3 p.m. and 8 p.m.[6] Children ages 6 to 17 are also more likely to be the victims of violent crime between 2 p.m. and 6 p.m.[7]

Low-income children and children in urban or high-crime neighborhoods are most at risk when they spend time caring for themselves and are most likely to benefit from high quality after-school programming.[8]

When school is out, children and young adolescents need a safe place that does not simply duplicate the school day. They need access to a wide variety of enriching activities — homework and reading help, sports, music, theater, art — and the opportunity to build meaningful relationships with their peers and caring adults.[9] Programs for older youth can be particularly successful if they treat youth as a resource and provide opportunities to contribute to the community.[10]

Children in high quality, well-designed after-school programs and extracurricular activities have better peer relations, emotional adjustment, grades, and conduct in school than their peers without such opportunities. They are less likely to use drugs or become teen parents.[11] Yet, many after-school programs are of poor quality due to a lack of resources, staff turnover, and inappropriate space. Resources are particularly scarce in low-income communities where they are needed most.[12,13,14]

School-Aged Child Care Capacity, Rhode Island and Core Cities, 1996 to 2001



Source: Options for Working Parents, 1996-2001. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls. Note: Data for 1997 are not available.

◇ Rhode Island's licensed child care capacity for school-aged children has grown from 6,692 slots in 1996 to 12,592 slots in 2001. While Rhode Island's overall capacity has been growing steadily, the capacity in the core cities peaked in 1999 at 5,877 slots and has declined to 5,173 in 2001.

◇ Under Starting Right, Rhode Island's child care law, child care subsidies are an entitlement for all families with incomes less than 225% of poverty. Subsidies can be used for after-school programs for children up to age 16. As of December 2001, 35% of the 12,682 children who were receiving subsidies were ages 6 to 11 and 3% were ages 12 to 14. Fewer than 1% were ages 15 and 16.[15]

◇ The state of Rhode Island has made funds available to local school districts through Article 31, the state's educational aid law, for purposes that include before-school and after-school care. These funds are being used for after-school programs in East Providence, Pawtucket, Providence, West Warwick and Woonsocket.[16,17]

Table 26.

Licensed School-Age Child Care for Children Ages 5 to 12, Rhode Island, 2001

	COMMUNITY-BASED		SCHOOL-BASED		TOTAL	
CITY/TOWN	PROGRAMS	SLOTS	PROGRAMS	SLOTS	PROGRAMS	SLOTS
Barrington	5	206	0	0	5	206
Bristol	3	52	1	50	4	102
Burrillville	1	38	2	135	3	173
Central Falls	1	49	3	182	4	231
Charlestown	0	0	1	26	1	26
Coventry	3	84	9	475	12	559
Cranston	10	313	8	272	18	585
Cumberland	0	0	5	225	5	225
East Greenwich	0	0	2	130	2	130
East Providence	3	130	13	702	16	832
Exeter	1	26	2	70	3	96
Foster	2	68	0	0	2	68
Glocester	0	0	1	75	1	75
Hopkinton	0	0	0	0	0	0
Jamestown	0	0	1	50	1	50
Johnston	3	65	3	139	6	204
Lincoln	2	45	2	130	4	175
Little Compton	1	26	0	0	1	26
Middletown	3	58	5	231	8	289
Narragansett	0	0	1	60	1	60
Newport	1	52	7	293	8	345
New Shoreham	0	0	0	0	0	0
North Kingstown	4	121	3	204	7	325
North Providence	1	100	1	50	2	150
North Smithfield	0	0	1	100	1	100
Pawtucket	6	654	6	344	12	998
Portsmouth	2	92	0	0	2	92
Providence	22	1,529	21	1,731	43	3,260
Richmond	0	0	0	0	0	0
Scituate	2	7	1	43	3	50
Smithfield	3	98	2	200	5	298
South Kingstown	1	18	7	332	8	350
Tiverton	2	95	0	0	2	95
Warren	1	85	2	100	3	185
Warwick	14	715	10	431	24	1,146
Westerly	4	133	5	206	9	339
West Greenwich	1	18	0	0	1	18
West Warwick	2	119	5	271	7	390
Woonsocket	3	157	3	182	6	339
Core Cities	*33*	*2,441*	*40*	*2,732*	*73*	*5,173*
Remainder of State	*74*	*2,712*	*93*	*4,707*	*167*	*7,419*
Rhode Island	*107*	*5,153*	*133*	*7,439*	*240*	*12,592*

Source of Data for Table/Methodology

All data are from Options for Working Parents, Greater Providence Chamber of Commerce, December 2001.

Number of licensed school-age child care programs and slots for children ages 5 to 12 as of December 2001. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 5 to 12 that do not require licensing by the state.

See methodology on p. 123.

References for Indicator

[1,2,3,7] *Fact Sheet on School-Age Children's Out-of-School Time* (March 2001). Wellesley, MA: National Institute on Out-of-School Time.

[3] *Child Care Patterns of School-Age Children with Employed Mothers* (September 2000). Washington, DC: The Urban Institute.

[4] *A Matter of Time: Risk and Opportunity in the Non-school Hours* (1994). New York: Carnegie Corporation.

[5] Fox, J., et al. (1997). *After-School Crime or After-School Programs: A Report to the Attorney General.* Washington, DC: Fight Crime, Invest in Kids.

[6] Vandell, D.L., et al. "After-School Child Care Programs" in *When School is Out* (Fall 1999). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[7,11] *Making an Impact on Out-of-School Time* (June 2000). Wellesley MA: National Institute on Out-of-School Time.

[8,9,10] Quinn, J. "Where Need Meets Opportunity: Youth Development Programs for Early Teens" in *When School is Out* (Fall 1999). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[12] Halpern, R. "After-School Programs for Low-Income Children: Promise and Challenges" in *When School is Out* (Fall 1999). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[13] *Working for Children and Families: Safe and Smart After-School Programs* (April 2000) Washington, DC: U.S. Department of Education, Partnership for Family Involvement in Education.

[14] Rhode Island Department of Human Services. INRHODES Database, December 2001.

[15] Rhode Island Department of Elementary and Secondary Education, Office of Integrated Social Services, 2002.

[16] *Building an Early Care and Education System in Rhode Island: Rhode Island KIDS COUNT Special Report* (December 1999). Providence, RI: Rhode Island KIDS COUNT.

Children Receiving Child Care Subsidies

DEFINITION

Children receiving child care subsidies is the number of children receiving child care that is either fully or partially paid for with a child care subsidy from the Rhode Island Department of Human Services. Child care subsidies are available to families with income at or below 225% of the federal poverty level ($39,713 for a family of four). Child care subsidies can be used for care by a child care center, family child care home, a relative, or an in-home caregiver.

SIGNIFICANCE

Families rely on child care to enable them to work and to provide the early education experiences needed to prepare their children for school.[1] Yet the high cost of child care puts quality care out of reach for many families, particularly low-income families.[2] National studies have shown that child care subsidies increase the likelihood that low-income parents, particularly current or former welfare recipients, will be able to work.[3]

In 1997, families with earnings below the federal poverty level who paid for child care spent 23% of their earnings, low-income families without subsidies spent 16% of their earnings and higher-income families spent 6% of their earnings for child care.[4] Families with younger children spent a higher share of income on child care than families with older children.[5] Low-skilled single mothers who pay for child care spend the highest proportion of their income on child care.[6]

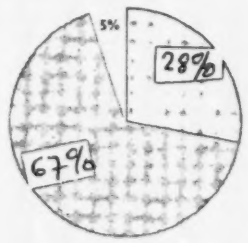
The quality and stability of child care is critical to a parent's ability to work and to child development.[7,8] Parents of children in quality child care programs are more likely to be productive workers because they are less hampered by child care problems that result in frequent employee turnover and absenteeism.[9]

Rhode Island is the only state that has a legal entitlement to a child care subsidy for income-eligible families. Working families with incomes up to 225% of the federal poverty line are entitled to a child care subsidy for their children up to age 16. Co-payments are required for families with incomes over the federal poverty level ($17,650/year for a family of four). Reimbursement rates for child care providers who accept subsidies are set at the 75th percentile of the child care market rate in order to provide low-income families with access to a large proportion of the child care that exists, including higher quality care.[10,11]

Child Care Subsidies, Rhode Island, December 2001

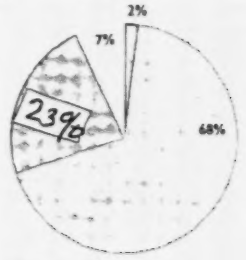
By Family Income

28%	Receiving Cash Assistance (FIP)
67%	Low-Income Working Families
5%	DCYF



By Provider Type

2%	In-Home
68%	Licensed Centers
23%	Family Child Care Homes
7%	Relative



Total Number of Subsidies is 12,682 as of December 2001.

Source: Rhode Island Department of Human Services, December 2001.

◇ In December 2001, more than two-thirds (67%) of all child care subsidies in Rhode Island were being used by low-income working families.[12] The cost of child care is often the largest expense, after housing, for working families who need full-time care for their children.[13]

◇ More than 90% of Rhode Island families receiving child care subsidies choose licensed child care centers or certified family child care homes for their child care arrangements.[14]

◇ As of December 2001, 25% of child care subsidies were used for infants and toddlers up to age 3, 37% were for used for preschoolers ages 3 to 5, 35% were used for school-age children ages 6 to 11, 3% were used for children ages 12 to 14, and fewer than 1% were used for teens ages 15 and 16.[15]

◇ Even as more child care subsidies become available, there is a structural shortage of high quality, regulated child care slots necessary to meet demand. The supply of licensed and certified child care is especially limited in low-income communities and rural areas, for infants and children under age 3, for children with disabilities and special health care needs, for middle school-age children, and for parents with unconventional or shifting work hours.[16]

BEST COPY AVAILABLE

Table 27.

Child Care Subsidies, Rhode Island, 2001

CITY/TOWN	COMMUNITY CONTEXT: # OF CHILDREN UNDER AGE 16 IN WORKING FAMILIES < 185% POVERTY	COMMUNITY CONTEXT: # OF CHILDREN UNDER AGE 16 ENROLLED IN FIP*	NUMBER OF CHILD CARE SUBSIDIES: BIRTH TO AGE 3	NUMBER OF CHILD CARE SUBSIDIES: AGES 3-5	NUMBER OF CHILD CARE SUBSIDIES: AGES 6-16	NUMBER OF CHILD CARE SUBSIDIES: TOTAL CHILD CARE SUBSIDIES
Barrington	49	29	19	26	33	78
Bristol	809	138	10	40	38	88
Burrillville	518	118	5	4	22	31
Central Falls	2,935	1,729	51	56	49	156
Charlestown	152	65	3	6	1	10
Coventry	748	279	45	41	39	125
Cranston	1,734	1,088	180	287	295	762
Cumberland	540	158	38	48	24	110
East Greenwich	81	71	33	39	7	79
East Providence	2,352	721	116	189	178	483
Exeter	149	40	2	5	4	11
Foster	109	19	7	7	3	17
Glocester	265	49	8	11	0	19
Hopkinton	154	62	13	6	2	21
Jamestown	55	9	5	5	4	14
Johnston	587	338	57	79	65	201
Lincoln	270	138	45	50	49	144
Little Compton	47	4	0	0	1	1
Middletown	542	112	53	110	26	189
Narragansett	333	91	20	23	11	54
New Shoreham	13	2	0	0	0	0
Newport	1,489	942	79	96	75	250
North Kingstown	590	250	35	76	93	204
North Providence	729	363	40	75	27	142
North Smithfield	141	29	0	3	8	11
Pawtucket	6,851	3,030	314	557	688	1,559
Portsmouth	190	52	11	12	11	34
Providence	16,851	13,937	1,238	1,617	2,001	4,856
Richmond	142	32	6	3	2	11
Scituate	166	36	8	16	14	38
Smithfield	170	41	29	48	16	93
South Kingstown	377	222	36	83	40	159
Tiverton	290	84	10	20	14	44
Warren	488	133	48	65	68	181
Warwick	2,244	784	236	314	354	904
West Greenwich	109	26	17	12	6	35
West Warwick	1,363	652	74	114	104	292
Westerly	657	258	11	45	35	91
Woonsocket	3,572	2,182	134	193	158	485
Out-of-State	*0*	*0*	*24*	*35*	*12*	*71*
Core Cities	*31,698*	*21,820*	*1,816*	*2,519*	*2,971*	*7,306*
Remainder of State	*17,163*	*6,493*	*1,244*	*1,897*	*1,606*	*4,747*
Rhode Island	*48,861*	*28,313*	*3,060*	*4,416*	*4,577*	*12,053*

*FIP is the Family Independence Program.

Notes to Table

The total number of child care subsidies listed in this table differs from the total reported in the pie chart because the table reports authorized payments while the pie chart uses payroll data that include children for whom retroactive payments were made in December.

Parents who are working and are enrolled in the Family Independence Program (FIP) can claim a child care disregard. When DHS calculates cash benefits levels based on monthly income, the child care disregard allows families to not count or disregard up to $200 of their monthly income that they can designate for child care expenses. The child care disregard is a form of subsidy not included in this table.

Source of Data for Table/Methodology

The Rhode Island Department of Human Services, INRHODES Database, December 1, 2001. Providence Chamber of Commerce, Options for Working Parents, December 1, 2001. All data are reported by location of the child care program not the residence of the child. See methodology on page 124.

References for Indicator

[1] Schulman, K., et al. (November 2001). *A Fragile Foundation: State Child Care Assistance Policies.* Washington, DC: Children's Defense Fund.

[2] Schulman, K. (2000). *The High Cost of Child Care Puts Quality Care Out of Reach for Many Families.* Washington, DC: Children's Defense Fund.

[3] Blau, D. et al. (January 2001). *The Determinants and Consequences of Child Care Subsidy Receipt by Low-Income Families.* Chapel Hill, NC: Department of Economics, University of North Carolina, Chapel Hill.

[4,5,6] Giannarelli, L. et al. (2000) *Child Care Expenses of America's Families* (2000). Washington, DC: The Urban Institute.

[8] Anderson, P.M. et al (2000). "Child Care and Mother's Employment Decisions." In *Finding Jobs.* New York, NY: Russell Sage Foundation.

[7] Culkin, M.L., et al.(December 1997). *Building Blocks: A Legislator's Guide to Child Care Policy.* Denver, CO: National Conference of State Legislatures.

[9] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[9] *Why Child Care Matters* (1993). New York, NY: The Committee for Economic Development.

[10,11] *Rhode Island KIDS COUNT Special Report: Building an Early Care and Education System in Rhode Island* (December 1999). Providence, RI: Rhode Island KIDS COUNT.

[11] *Starting Right: Quality Early Education and Child Care for Rhode Island's Children and Youth* (July 2000). Cranston, RI: Rhode Island Department of Human Services.

[12,13,15] Rhode Island Department of Human Services, INRHODES Database, December 2001.

Full-Day Kindergarten

DEFINITION

Full-day kindergarten is the percentage of public school kindergarten children enrolled in a full-day kindergarten program. Full-day kindergarten is defined as a kindergarten program that operates for at least six hours per day. The numbers do not include children enrolled in private kindergarten programs or in half-day kindergarten programs that offer after-school child care.

SIGNIFICANCE

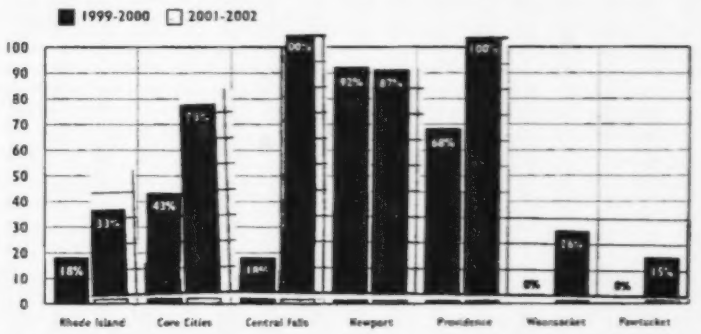
Research shows that many children benefit academically from participation in full-day kindergarten and are more likely to be ready for first grade than children in half-day kindergarten programs.[1,2] Full-day kindergarten programs are especially beneficial to children from low-income and educationally disadvantaged backgrounds.[3]

The increase in single parent families, the increase in the number of families with both parents working, and the fact that most children have experience with full-day preschool or child care programs have increased the demand for full-day kindergarten. Studies show that parents favor a full-day program that reduces the number of transitions that their kindergarten child must make each day.[4,5]

Teachers and parents report that full-day children have more time to discover at a relaxed pace, more opportunities to choose activities and develop their own interests, and more time for creative activities.[6] The longer school day allows children and teachers time to explore topics in depth; provides for greater continuity of daily activities, and creates an environment that supports a child-centered, developmentally-appropriate approach. Full-day kindergartners exhibit more independent learning, classroom involvement, productivity in work with peers, and reflectiveness than half-day kindergartners.[7] Children in full-day programs are more likely to understand a broader range of letter-sound relationships, recognize words by sight, and understand words in context.[8]

Teachers in full-day programs are better able to assess children's progress.[9] In a full-day program, teachers and school staff have more opportunities to recognize a child's learning style and identify problems or behavioral issues. This allows for more timely intervention and the potential to reduce costs associated with remedial education and special education costs in later school years.[10,11]

Children in Full-Day Public Kindergarten Programs, Rhode Island and Core Cities, 1999-2000 and 2001-2002



Source: Rhode Island Department of Elementary and Secondary Education, 1999-2000 and 2001-2002 school years.

◆ In 2001-2002, 33% of Rhode Island children who attended public kindergarten were in a full-day program, up from 28% in 2000-2001 and 18% in 1999-2000. Nationwide, approximately 50% of kindergarteners were in a full-day program.[12,13,14]

◇ 73% of children in the core cities attended full-day kindergarten programs in 2001-2002, up from 59% in 2000-2001 and 43% in 1999-2000.

◇ Of Rhode Island's thirty-six school districts, six offer universal access to full-day kindergarten. The remaining school districts with full-day kindergarten select children for the full-day program by residence, lottery or based on special needs or risk categories.[15]

◇ Full-day kindergarten helps to reduce academic disparities among students as they enter the first grade. Research indicates that children who attend full-day kindergarten score higher on first-grade reading readiness tests and on reading and achievement tests in the elementary grades.[16,17]

Table 28. **Children Enrolled in Full-Day Kindergarten Programs, Rhode Island, 1999-2000 and 2001-2002**

SCHOOL DISTRICT	1999-2000 SCHOOL YEAR			2001-2002 SCHOOL YEAR		
	TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL-DAY K	% OF CHILDREN IN FULL-DAY K	TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL DAY K	% CHILDREN IN FULL DAY K
Barrington	214	0	0%	194	5	3%
Bristol-Warren	255	0	0%	268	25	9%
Burrillville	164	0	0%	156	57	37%
Central Falls	250	44	18%	269	269	100%
Chariho	292	0	0%	264	46	17%
Coventry	381	0	0%	397	0	0%
Cranston	737	0	0%	705	2	0%
Cumberland	373	0	0%	397	15	4%
East Greenwich	165	0	0%	159	4	3%
East Providence	443	0	0%	403	0	0%
Exeter-W. Greenwich	129	0	0%	139	0	0%
Foster	55	0	0%	57	1	2%
Foster-Glocester	0	0	0%	0	0	0%
Glocester	124	0	0%	102	0	0%
Jamestown	59	0	0%	37	37	100%
Johnston	241	0	0%	259	18	7%
Lincoln	232	0	0%	233	0	0%
Little Compton	38	0	0%	37	0	0%
Middletown	258	211	82%	226	226	100%
Narragansett	125	0	0%	103	4	4%
Newport	225	206	92%	240	208	87%
New Shoreham	8	8	100%	13	12	92%
North Kingstown	313	0	0%	293	0	0%
North Providence	211	0	0%	180	0	0%
North Smithfield	122	55	45%	113	83	73%
Pawtucket	788	0	0%	682	103	15%
Portsmouth	214	0	0%	194	0	0%
Providence	2,117	1,431	68%	1,967	1,967	100%
Scituate	107	0	0%	118	15	13%
Smithfield	177	0	0%	188	0	0%
South Kingstown	278	0	0%	227	4	2%
Tiverton	144	0	0%	133	0	0%
Warwick	766	29	4%	744	43	6%
Westerly	282	10	4%	264	158	60%
West Warwick	260	0	0%	302	63	21%
Woonsocket	522	0	0%	498	130	26%
Core Cities	*3,902*	*1,681*	*43%*	*3,656*	*2,677*	*73%*
Remainder of State	*7,167*	*313*	*4%*	*6,905*	*818*	*12%*
Rhode Island	*11,069*	*1,994*	*18%*	*10,561*	*3,495*	*33%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1999 and 2001. Data are as of October 1999 and 2001 and are for the 1999-2000 and 2001-2002 school years.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[1,5,6,7] Clark, P. (June 2001). "Recent Research on All-Day Kindergarten." *ERIC Digest.* Champaign, IL: ERIC Clearinghouse on Elementary and Early Childhood Education.

[2,3] Hildebrand, C. (Fall 2000). "Effects of All-Day and Half-Day Kindergarten Programming On Reading, Writing, Math, and Classroom Social Behaviors." *National FORUM of Applied Educational Research Journal,* Volume 13E, No.3. Lake Charles, LA: The College of Education and Human Development, University of Louisiana at Monroe.

[2,3,4] *Learning to Learn: Full-Day Kindergarten for At-Risk Kids* (Revised, October 2000). Harrisburg, PA: Pennsylvania Partnership for Children.

[4] Rothenburg, D. (May 1995). "Full-Day Kindergarten Programs." *ERIC Digest.* Champaign, IL: ERIC Clearinghouse on Elementary and Early Childhood Education.

[5,6] West, J. et al. (2000). *The Kindergarten Year: Findings from the Early Childhood Longitudinal Study,* Kindergarten Class of 1998-99.

[7] Elicker, J. et al.(1997). "What Do They Do All Day? Comprehensive Evaluation of a Full-Day Kindergarten." *Early Childhood Research Quarterly,* 12(4). Indianapolis, IN: Department of Child Development and Family Studies, Purdue University.

[7] National Association of School Psychologists (1997). *Full-day Versus Half-day Kindergarten Programs: A Brief History and Synopsis.*

[8,9] Rhode Island Department of Elementary and Secondary Education, 1999, 2000 and 2001.

English Language Learners

DEFINITION

English language learners is the percentage of all public school children (pre-kindergarten through grade 12) who are receiving English as a Second Language services or Bilingual Education services in Rhode Island public elementary and secondary school districts. The term "Limited English Proficient students" has been replaced by the term "English language learners" in the education community.

SIGNIFICANCE

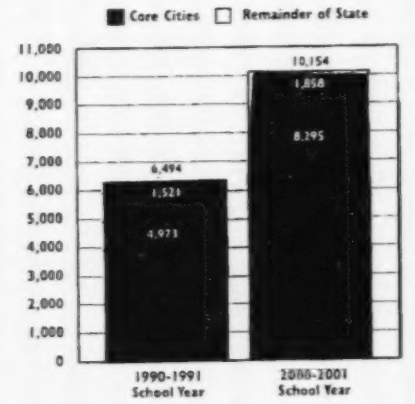
In 1999 there were 87,559 foreign-born individuals residing in Rhode Island; of these, 6,798 were children under the age of 18. This is about 3% of the child population in the state.[1] A far greater number of Rhode Island children live in households headed by an immigrant. In 1999, immigrants headed 42,075 Rhode Island households with children under age 18.[2]

Children of recent immigrants are at very high risk for difficulties at school. They face multiple risk factors including poverty, non-English speaking backgrounds, low educational level of parents, and discrimination based on race, ethnic background, culture, or language.[3] Adults who report that they have some difficulty with English are twelve times as likely to have completed less than five years of schooling and half as likely to have graduated from high school. Children who live in these households are fifty percent more likely to live in poverty.[4] These children are also most likely to be concentrated in under-resourced schools in high poverty communities.[5]

Of all public agencies, schools have been among the most dramatically affected by the increase in immigrant children and children of immigrants. Schools play a critical role in helping children to transition to the culture of the United States and in providing an education that supports academic success for children with a primary language other than English.[6]

In the 2000-2001 school year, there were 10,154 school-aged Rhode Island children who were English language learners, 6% of all students enrolled statewide.[7] Children who are English language learners need developmental programs that begin with accurately assessing each child's abilities and knowledge in their own language.[8] Effective programs for English language learners comprehensively address the sociocultural processes of acclimating to a new culture.[9]

English Language Learners, Rhode Island, 1990 and 2000



Source: *Results: Education in Rhode Island 2001* (2001). Providence, RI: Rhode Island Public Expenditure Council and the Rhode Island Department of Elementary and Secondary Education. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

◇ Over the last decade, the number of English language learners in Rhode Island has increased by 56%, from 6,494 students in 1990-1991 to 10,154 students in 2000-2001. Nearly all of the increase has been in the school districts of the core cities.[10]

◇ The Rhode Island Department of Education is legally mandated to provide programs to English language learners that are comparable in structure and content to instruction provided to their English proficient peers.[11]

◇ Programs must focus on full English language literacy and all programs must have a process for evaluating the adequate yearly progress of each English language learner including those who have left the English as a Second Language (ESL) system.[12]

Table 29.

English Language Learners, Rhode Island, 2000-2001

SCHOOL DISTRICT	TOTAL ENROLLMENT IN DISTRICT	NUMBER OF ENGLISH LANGUAGE LEARNERS					% OF TOTAL DISTRICT
		PRE K AND K	ELEMENTARY GRADES 1-5	MIDDLE GRADES 6-8	HIGH GRADES 9-12	TOTAL ELL	
Barrington	3,241	1	12	3	1	17	1%
Bristol-Warren	3,792	12	87	12	4	115	3%
Burrillville	2,820	0	0	0	0	0	0%
Central Falls	3,489	132	539	200	182	1,053	30%
Chariho	3,909	1	5	2	5	13	0%
Coventry	5,730	7	5	1	1	14	0%
Cranston	11,040	44	211	105	88	448	4%
Cumberland	5,244	10	96	37	22	165	3%
East Greenwich	2,406	3	11	2	3	19	1%
East Providence	6,605	79	232	51	67	429	6%
Exeter-W. Greenwich	2,135	1	4	3	2	10	0%
Foster	411	0	0	0	0	0	0
Foster-Glocester	1,597	0	0	0	0	0	0%
Glocester	843	0	0	0	0	0	0%
Jamestown	645	0	1	0	0	1	0%
Johnston	3,492	5	23	16	13	57	2%
Lincoln	3,645	8	11	4	6	29	1%
Little Compton	341	0	0	0	0	0	0%
Middletown	2,817	6	20	15	13	54	2%
Narragansett	1,782	1	10	0	0	11	1%
New Shoreham	130	0	1	2	0	3	2%
Newport	3,041	0	53	16	15	84	3%
North Kingstown	4,486	4	29	9	19	61	1%
North Providence	3,549	8	62	19	25	114	3%
North Smithfield	1,852	0	0	0	0	0	0%
Pawtucket	10,069	62	559	286	259	*1,167	12%
Portsmouth	2,869	0	2	0	0	2	0%
Providence	26,859	709	3,405	871	607	5,592	21%
Scituate	1,709	0	0	0	0	0	0%
Smithfield	2,704	0	0	0	0	0	0%
South Kingstown	4,328	1	23	9	5	38	1%
Tiverton	2,201	0	0	0	0	0	0%
Warwick	12,265	13	53	17	10	93	1%
West Warwick	3,736	25	27	11	11	74	2%
Westerly	3,659	21	14	5	9	49	1%
Woonsocket	6,756	61	263	48	28	400	6%
State Run Schools	*1,150*	*0*	*0*	*0*	*42*	*42*	*4%*
Core Cities	*50,214*	*964*	*4,819*	*1,421*	*1,091*	*8,295*	*17%*
Remainder of State	*107,133*	*250*	*939*	*323*	*346*	*1,858*	*2%*
Rhode Island	*157,347*	*1,214*	*5,758*	*1,744*	*1,437*	*10,154*	*6%*

* *Includes one student in an ungraded class.*

Sources of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year. Total number of English language learners is the number of students in each district who were actively enrolled in English as a Second Language (ESL) or Bilingual Education Programs in the 2000-2001 school year. Students who are not yet fully English proficient but have exited the ESL or bilingual program to regular education are not included in these numbers. Denominator is the fall enrollment figures by district.

State Run Schools include Davies Vocational Technical School, Metropolitan Career Tech and Rhode Island School for the Deaf.

References

[1] US Census Bureau, Current Population Survey, 1997-2001 average.

[2] *Information Works!* (2000). Providence RI: Rhode Island Department of Elementary and Secondary Education and University of Rhode Island, National Center on Public Education and Social Policy.

[3] Crawford, James (1997). *Best Evidence: Research Foundations for the Bilingual Education*. Washington, DC: National Clearinghouse for Bilingual Education.

[4] Ruiz-de-Velasco, J. and Fix, M. (2001). *Overlooked and Underserved: Immigrant Students in U.S. Secondary Schools*. Washington, DC: Urban Institute.

[5] Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

[6] Collier, V. (Fall 1995). "Acquiring a Second Language for School" in *Directions in Language and Education*, Vol. 1 No. 4. Washington, DC: National Clearinghouse for Bilingual Education.

[7] *Results: Education in Rhode Island 2001* (2001). Providence, RI: Rhode Island Public Expenditure Council and the Rhode Island Department of Elementary and Secondary Education.

[8,9] Rhode Island Department of Elementary and Secondary Education. Limited English Proficiency (LEP) Regulations Chapter 16-54 2000.

Children Enrolled in Special Education

DEFINITION

Children enrolled in special education is the percentage of children ages 3 to 21 who are enrolled in special education in Rhode Island elementary and secondary schools.

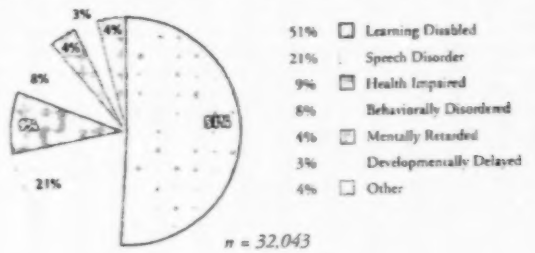
SIGNIFICANCE

Special education services are an important resource for improving long-term outcomes for children with special needs, such as improving student achievement and graduation rates, increasing participation in post-secondary education, and reducing disproportionately high rates of single parenthood.[1] In the 2000-2001 school year in Rhode Island, 21% of public school students were receiving special education services.[2]

The federal Individuals with Disabilities Education Act (IDEA) mandates that local school districts identify and provide multidisciplinary evaluations for students ages 3 to 21 whom they have reason to believe are students with disabilities. Once found eligible for special education due to disability, a student must be provided with an Individualized Education Plan (IEP) laying out goals, outlining specific steps for achieving the goals, and providing services for the student based on individual needs. The IEP is written by a team comprised of the child's teacher, parents or guardians, specialized school staff and administrators. In addition to educational services, schools must provide the related services needed for a child to benefit from his or her schooling. These may include physical therapy, mental health services, school health services, social work services, and parent counseling and training.[3]

Services described in the IEP must be provided in the least restrictive environment, i.e. to the extent appropriate, the child should receive special services in a setting that is integrated with other children with and without disabilities. This is sometimes referred to as inclusion or mainstreaming. Inclusion is not mandated if it would not be appropriate to a child's needs. Inclusion is meant to raise expectations for student performance, improve opportunities for the child with disabilities to learn alongside nondisabled peers, improve coordination between regular and special educators, and increase schools' accountability for performance. Inclusion rates for students with almost all disability types have increased during the 1990s.[4,5,6,7]

Special Education, By Type of Disability, Rhode Island, School Year 2000-2001



n = 32,043

◇ In the 2000-2001 school year, there were 32,043 Rhode Island children who received special education services. Of these, more than half were receiving services because of learning disabilities.

Source: The Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 2001

Education Outcomes for Children with Disabilities

◇ Nationally, young people with disabilities drop out of school at twice the rate of their peers. The rates are higher for minority students with disabilities and students with severe disabilities.[8]

◇ High school graduation rates vary by type of disability. Students with speech or language impairments, specific learning disabilities, and visual impairments are among the most likely to finish high school.[9]

◇ Students with disabilities are less likely than their non-disabled peers to take a full academic curriculum in high school, limiting their post-secondary options.[10]

Table 30

Children and Youth in Special Education, by Primary Disability, Ages 3-21, Rhode Island, 2000-2001

SCHOOL DISTRICT	TOTAL # OF STUDENTS	BEHAVIORALLY DISORDERED	MENTALLY RETARDED	ORTHO-PEDICALLY IMPAIRED	HEALTH IMPAIRED	LEARNING DISABLED	SPEECH DISORDER	DEVELOP-MENTALLY DELAYED	OTHER	TOTAL STUDENTS WITH DISABILITIES	% STUDENTS IN SPECIAL EDUCATION
Barrington	3,147	52	17	3	37	264	138	21	27	559	18%
Bristol-Warren	3,684	43	51	5	16	474	186	26	20	821	22%
Burrillville	2,690	80	27	1	93	222	112	16	24	575	21%
Central Falls	3,568	103	52	1	64	510	99	41	16	886	25%
Chariho	3,726	48	13	9	50	337	194	17	35	703	19%
Coventry	5,471	67	45	4	60	776	122	40	21	1,135	21%
Cranston	10,560	121	36	5	113	1,507	345	64	56	2,247	21%
Cumberland	5,082	118	25	6	300	339	318	43	51	1,200	24%
East Greenwich	2,313	24	3	4	90	149	110	15	29	424	18%
East Providence	6,419	120	62	2	272	454	363	33	57	1,363	21%
Exeter-W. Greenwich	2,068	36	10	4	99	86	130	7	8	380	18%
Foster	397	2	1	0	3	12	38	0	2	58	15%
Foster-Glocester	1,569	9	8	2	16	156	38	0	5	234	15%
Glocester	788	6	9	1	13	50	84	6	10	179	23%
Jamestown	774	3	2	2	30	56	29	3	9	134	17%
Johnston	3,249	46	28	3	115	361	220	17	19	809	25%
Lincoln	3,600	38	22	2	145	283	122	33	38	683	19%
Little Compton	434	3	2	0	4	42	21	1	3	76	18%
Middletown	2,699	41	10	0	63	267	148	11	17	557	21%
Narragansett	1,706	36	1	3	59	198	125	5	16	443	26%
Newport	2,998	96	9	13	22	498	118	23	30	809	27%
New Shoreham	126	2	0	0	0	10	16	3	0	31	25%
North Kingstown	4,212	47	10	6	39	398	217	21	15	753	18%
North Providence	3,490	69	16	5	108	327	185	32	26	768	22%
North Smithfield	1,838	20	9	1	52	155	91	9	13	350	19%
Pawtucket	9,814	230	148	5	123	942	496	110	77	2,131	22%
Portsmouth	2,811	28	7	3	61	193	179	3	28	502	18%
Providence	26,957	390	339	11	45	3,401	755	105	90	5,136	19%
Scituate	1,723	6	4	2	34	92	140	6	13	297	17%
Smithfield	2,637	9	8	3	63	212	143	15	16	469	18%
South Kingstown	4,221	68	25	6	100	352	223	21	33	828	20%
Tiverton	2,119	22	6	1	35	229	130	5	14	442	21%
Warwick	11,955	199	81	19	291	1,371	302	223	81	2,567	21%
Westerly	3,532	65	9	6	81	307	212	26	28	734	21%
West Warwick	3,797	99	17	0	15	448	187	29	26	821	22%
Woonsocket	6,638	217	143	7	302	612	277	64	61	1,683	25%
State Run Schools	*987*	*10*	*1*	*0*	*11*	*121*	*12*	*0*	*95*	*250*	*25%*
Charter School	*79*	*0*	*0*	*0*	*0*	*6*	*0*	*0*	*0*	*6*	*8%*
Core Cities	*49,975*	*1,036*	*691*	*37*	*556*	*5,963*	*1,745*	*343*	*274*	*10,645*	*21%*
Remainder of State	*103,903*	*1,537*	*565*	*108*	*2,468*	*10,254*	*4,880*	*751*	*835*	*21,398*	*21%*
Rhode Island	*153,878*	*2,573*	*1,256*	*145*	*3,024*	*16,217*	*6,675*	*1,094*	*1,109*	*32,043*	*21%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year. Office of Special Education. June 30, 2001.

Number of students is the resident average daily membership as calculated by the RI Department of Elementary and Secondary Education.

Other includes deaf and blind, visually impaired or blind, multi-handicapped, autistic, and traumatic brain injury.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the number of students enrolled in the school district.

State-Run Schools includes Davies Vocational Technical School, Metropolitan Career Tech and Rhode Island School for the Deaf. The Training School is not included.

References

[1] Terman, et al. (Spring 1996). "Special Education for Students with Disabilities: Analysis and Recommendations" in *Special Education for Students with Disabilities*. Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[2] Rhode Island Department of Education, IDEA data, 2000-2001 school year.

[3] Martin, E.W. et. al. "The Legislative and Litigation History of Special Education" in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[4] "Quality of Education Environments" (1999) in *The Condition of Education*. Washington, DC: National Center for Education Statistics.

[5] "Quality of Education Environments" (2001) in *The Condition of Education*. Washington, DC: National Center for Education Statistics.

[6] [7] *Twenty-four Years of Educating Children with Disabilities* (2001). Washington, DC: American Youth Policy Forum and Center on Education Policy.

Student Mobility

DEFINITION

Student mobility is the number of students who either enrolled in or withdrew from Rhode Island public schools during the school year divided by the number of students in the fall school enrollment. Percentages are reported for each school district overall as well as for their elementary schools, middle schools, and high schools.

SIGNIFICANCE

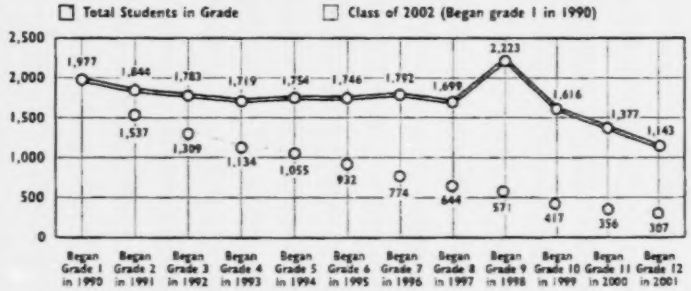
One in six third-grade students in the U.S. has attended at least three schools since the beginning of the first grade.[1] Student mobility affects both the student and the classrooms they attend. Changing schools causes a disruption in a child's learning experience and may accentuate learning difficulties if the child enters a classroom at a different point in the curriculum than in their previous school.[2] Children must adjust to new schools, friends and neighbors. Research shows that frequent moves can have a negative affect on school performance and behavior.[3] Teachers in schools with highly mobile students are more likely to have problems accurately assessing the needs of new children, determining their past educational experiences, and being able to build on the student's knowledge and skills.[4]

Nationally, minority children, children living in low-income households or renter households and immigrants have high rates of mobility.[5] Children who are English language learners (ELL students) are more than twice as likely to change schools frequently as are non-ELL students.[6] Rhode Island ELL students are highly concentrated in the three communities with high school mobility rates: Central Falls, Providence and Pawtucket.[7]

The overall school mobility rate for Rhode Island was 19% for the 2000-2001 school year, but there was significant variation across school districts, with a high student mobility rate of 44% in Central Falls to a low of 4% in Barrington and Jamestown.[8,9] The core cities (the five communities with greater than 15% of children living in poverty) have a significantly higher mobility rate (31%) than schools in the remainder of the state (14%).[10]

Families move for a variety of reasons that may include changes in household structure, parental employment status, an inability to pay the rent, dissatisfaction with neighborhood conditions or a desire to improve overall quality of family life.[11,12]

Providence's Class of 2002, Churning Analysis 1990 to 2001



Source: The Providence Plan analysis of data from the Providence School District, 2002 (October enrollment data) in 2001 "Class of 2002" is the class that began Grade 1 in 1990.

◇ Of the 1,977 children who entered first grade in Providence in 1990, only 307 (16%) were still in the Providence school system in twelfth grade. The group of leavers included students who had moved to another community, transferred to a private or parochial school, returned to their country of origin, dropped out, or were assigned to another grade or a special education class.[15]

◇ Churning is a demographic term to describe the process of one group replacing another within a particular geographic area. In the Providence school district, only 53% of the children who entered in first grade were still with their peers by fifth grade.[16]

◇ Mobility has a strong relationship to child well-being. Frequent moves are often correlated with such negative outcomes as dropping out of school, delinquency, depression and teen births.[17]

◇ Other forms of change – including changes in household structure or family composition, residence, parental employment status or the health of a parent or sibling – may also be harmful to children, especially when multiple changes occur in several areas of the child's life over a short period of time.[18]

Table 31.

School Mobility by District, Rhode Island, School Year 2000-2001

DISTRICT	ELEMENTARY SCHOOLS	MIDDLE / JUNIOR HIGH SCHOOLS	HIGH SCHOOLS	TOTAL DISTRICT MOBILITY
Barrington	4%	2%	5%	4%
Bristol-Warren	9%	8%	13%	10%
Burrillville	20%	11%	15%	16%
Central Falls	45%	40%	45%	44%
Chariho	9%	7%	20%	12%
Coventry	11%	3%	10%	10%
Cranston	16%	12%	18%	16%
Cumberland	11%	9%	7%	9%
East Greenwich	7%	4%	10%	7%
East Providence	12%	10%	11%	14%
Exeter-West Greenwich	10%	5%	8%	9%
Foster	6%	NA	NA	6%
Foster-Glocester	NA	9%	7%	8%
Glocester	5%	NA	NA	5%
Jamestown	4%	3%	NA	4%
Johnston	12%	NA	NA	12%
Lincoln	9%	10%	6%	8%
Little Compton	5%	NA	NA	5%
Middletown	27%	20%	14%	21%
Narragansett	11%	6%	15%	10%
New Shoreham	10%	NA	NA	10%
Newport	26%	19%	16%	22%
North Kingstown	10%	8%	11%	10%
North Providence	18%	4%	14%	16%
North Smithfield	11%	12%	12%	12%
Pawtucket	30%	17%	52%	29%
Portsmouth	16%	8%	NA	12%
Providence	30%	34%	37%	33%
Scituate	7%	5%	4%	6%
Smithfield	10%	4%	10%	9%
South Kingstown	7%	9%	NA	7%
Tiverton	6%	5%	10%	7%
Warwick	19%	9%	11%	15%
West Warwick	24%	27%	20%	24%
Westerly	12%	7%	9%	10%
Woonsocket	30%	26%	23%	27%
Other Schools	*NA*	*NA*	*18%*	*NA*
Core Cities	*31%*	*28%*	*35%*	*31%*
Remainder of State	*14%*	*9%*	*16%*	*14%*
Rhode Island	*18%*	*18%*	*21%*	*19%*

Sources

Mobility rates are calculated by adding all children who entered any school within the school district to all those who withdrew from a school in the district and dividing the total by the fall enrollment for that school district. If a child left one school within the district and entered another school in the same district during the school year, the child would be counted twice in the district's mobility rate. Because each district has different school configurations, mobility rates for elementary, middle/junior high, and high school are not exactly comparable by grade across districts. Only schools that reported data are included in the mobility calculations for the district. NA - data not available.

Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

References for Indicator

[1,2] *Elementary School Children: Many Change School Frequently, Harming Their Education* (February 1994). Washington, DC: U.S. General Accounting Office.

[2] Kerbow, D. (October 1996). *Patterns of Urban Students Mobility and Local School Reform: A Technical Report.* Baltimore, MD: Center for the Social Organization of Schools, Johns Hopkins University.

[3] *Kids Mobility Project Report* (January 2002). Minneapolis, MN: Family Housing Fund.

[4] *Geographical Mobility - Population Characteristics: March 1999 to March 2000* (May 2001). Washington, DC: U.S. Bureau of the Census.

[5,6,8] Rhode Island Department of Elementary and Secondary Education, *InfoWorks* 2000-2001.

[7] *Why People Move: Exploring the March 2000 Current Population Survey, March 1999 to March 2000* (May 2001). Washington, DC: U.S. Bureau of the Census.

[9] *Counting on Ourselves: The Providence Demography Initiative/A First Portrait: Schools* (1999). Providence, RI: The Providence Blueprint for Education (PROBE) and The Providence Plan.

[10] The Providence Plan analysis of data from the Providence School District, 2002. October enrollment data.

[11] *Trends in the Well-Being of America's Children and Youth* (2001). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[12] Anderson Moore, K., Vandivere, S. and Ehrle, J. (June 2000). *Turbulence and Child Well-Being.* Washington, DC: The Urban Institute and Child Trends.

Fourth-Grade Reading Skills

DEFINITION

Fourth-grade reading skills is the percentage of fourth-grade students who scored at or above the proficiency level for reading in the New Standards English Language Arts Reference Exam in 2001. The exam is made up of two parts: *Basic Understanding* focuses on the student's ability to comprehend and understand text, and *Interpretation and Analysis* focuses on the student's ability to correctly interpret and analyze text.

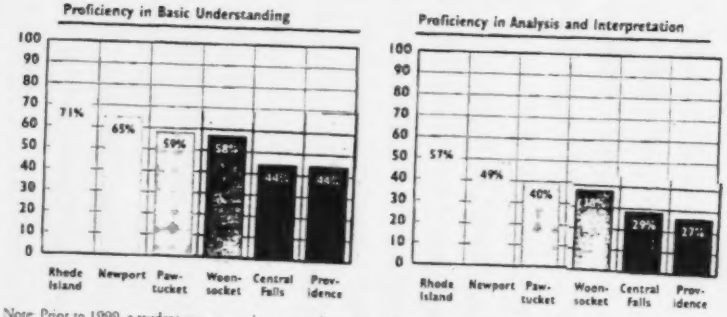
SIGNIFICANCE

Reading skills are critical to a student's success in school and in the workforce. Students who cannot read are more likely to be absent from school, exhibit behavior problems, have low levels of self-confidence, and perform poorly in school.[1] Parent education, language proficiency, family structure, and the community's socioeconomic status are strong predictors of student achievement in reading.[2,4,5] In the U.S., Hispanic children face the most barriers to reading proficiency because they are more likely to be poor, less likely to attend pre-school, and more likely to have parents that have not finished high school.[6]

Literacy begins long before children encounter formal school instruction in writing and reading. Reading to young children at home, encouraging conversation and print awareness makes a difference in subsequent reading achievement.[7,8,9] Participation in high-quality pre-schools can also boost language and literacy skills by helping children learn, think, and talk about new areas of knowledge; by integrating reading, letters, sounds, and storytelling into everyday activities; and by offering opportunities to play in ways that build awareness of the sounds and structure of language.[10]

For school-age children, out-of-school activities are important predictors of reading achievement. Children who report that they regularly read for fun on their own time, children who regularly discuss their reading with family and friends, and children who watch fewer hours of television consistently outperform their peers in reading proficiency.[11,12]

Rhode Island Public School 4th Grade Reading Proficiency, Core Cities and Rhode Island, 2000-2001



Note: Prior to 1999, a student was counted as a test taker only if they actually took the test and completed enough of it for a score to be calculated. As of 1999-2000, however, all students eligible to take the test are counted, whether or not they take the test or score. All students are eligible unless their IEP specifically exempts them or unless they are Beginning English Language Learners and are beginning level speakers and have been in the district for less than one year. As a result, overall proficiency rates, as reported here, are lower than they were under the previous system of scoring.

Source: Rhode Island Department of Elementary and Secondary Education, New Standards English Language Arts Reference Exam at Grade 4, 2000-2001 school year.

◇ In 2001, 71% of Rhode Island fourth graders scored at or above proficiency in *Basic Understanding* and 57% scored at or above proficiency in *Analysis and Interpretation*. Each of the five core cities had reading proficiency levels below the state rates.

◇ On the National Assessment of Educational Progress (NAEP), a federally-sponsored state survey, 32% of Rhode Island's fourth graders scored at or above proficient in 1998. This compares favorably to the national score of 29% in 1998.[13,14]

◇ Across the U.S., schools with high poverty rates have achieved high performance by emphasizing best practices such as standards for curriculum design and accountability; parent involvement; extra teaching time for the basics of reading and math; and immediate and intensive support for low-achieving students.[15]

BEST COPY AVAILABLE

Table 32

Fourth-Grade Reading Proficiency, Rhode Island, 2001

SCHOOL DISTRICT	COMMUNITY CONTEXT: % ADULTS COMPLETING HIGH SCHOOL	COMMUNITY CONTEXT: % CHILDREN IN POVERTY	COMMUNITY CONTEXT: % LIMITED ENGLISH PROFICIENCY	NUMBER OF 4TH GRADE TEST TAKERS	% OF 4TH GRADE STUDENTS MEETING STANDARD FOR BASIC UNDERSTANDING	% OF 4TH GRADE STUDENTS MEETING STANDARD FOR ANALYSIS & INTERPRETATION
Barrington	89%	2%	1%	273	95%	89%
Bristol-Warren	NA	14%	3%	299	76%	58%
Burrillville	71%	7%	0%	209	81%	63%
Central Falls	47%	36%	30%	289	44%	29%
Chariho	82%	9%	0%	312	86%	78%
Coventry	74%	8%	0%	458	80%	68%
Cranston	74%	11%	4%	887	85%	74%
Cumberland	75%	5%	3%	404	77%	67%
East Greenwich	90%	4%	1%	212	92%	86%
East Providence	67%	10%	6%	510	75%	61%
Exeter-W. Greenwich	78%	7%	0%	174	79%	61%
Foster	82%	11%	0%	83	84%	65%
Foster-Glocester	83%	8%	0%	NA*	NA	NA
Glocester	83%	11%	0%	154	82%	75%
Jamestown	89%	10%	0%	66	92%	80%
Johnston	67%	10%	2%	295	79%	64%
Lincoln	76%	10%	1%	330	85%	72%
Little Compton	86%	4%	0%	39	87%	72%
Middletown	85%	7%	2%	230	79%	68%
Narragansett	87%	8%	1%	142	81%	75%
Newport	84%	22%	3%	239	65%	49%
New Shoreham	94%	10%	2%	14	93%	93%
North Kingstown	86%	7%	1%	347	90%	81%
North Providence	71%	7%	3%	290	74%	62%
North Smithfield	72%	1%	0%	170	94%	82%
Pawtucket	62%	18%	12%	881	59%	40%
Portsmouth	86%	6%	0%	237	84%	79%
Providence	63%	41%	21%	2,304	44%	27%
Scituate	84%	5%	0%	128	87%	78%
Smithfield	81%	5%	0%	237	87%	80%
South Kingstown	86%	9%	1%	367	86%	78%
Tiverton	71%	9%	0%	162	78%	60%
Warwick	78%	9%	1%	966	75%	60%
Westerly	76%	10%	1%	291	82%	67%
West Warwick	70%	17%	2%	306	72%	56%
Woonsocket	56%	22%	6%	550	58%	38%
Core Cities	*NA*	*31%*	*17%*	*4,263*	*NA*	*NA*
Remainder of State	*NA*	*9%*	*2%*	*8,592*	*NA*	*NA*
Rhode Island	*72%*	*16%*	*6%*	*12,855*	*71%*	*57%*

Source of Data for Table/Methodology

Percent of adults completing high school are based on U.S. Bureau of the Census, 1990 Census of Population. Percentage of children in poverty is from the U.S. Census Bureau, Small Area Income and Population Estimates, Children Ages 5-17, 1997. Released November, 2000. All other data are from the Rhode Island Department of Elementary and Secondary Education, 2001. Core cities are Providence, Pawtucket, Central Falls, Woonsocket and Newport.

*NA: Community has a regional school.

See methodology on p. 124.

References for Indicator

[1] *Wasting America's Future* (1994). Washington, DC: The Children's Defense Fund.

[2] *America's Children: Key National Indicators of Well-Being* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[3] *The National Education Goals Report: Building a Nation of Learners* (1995). Washington, DC: U.S. Government Printing Office.

[4] Donahue, P. et. al. *The Nation's Report Card: Fourth Grade Reading 2000* (April 2001). Washington, DC: National Center for Education Statistics.

[5] *Trends in the Well-Being of America's Children and Youth: 2000* (2000). Washington, DC: U.S. Child Trends Inc., Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[6] Fletcher, M.A., "Latinos at the Back of the Class" in *Washington Post* (December 1998), based on a report by the National Council of La Raza.

[7] *Starting Out Right: A Guide to Promoting Children's Reading Success* (1998). The National Academy Press.

[8] *Developing and Supporting Literacy-Rich Environments for Children* (Issue Brief) (2001). Washington, DC: National Governor's Association Center for Best Practices.

[9] *Quality Counts 2002: Building Blocks for Success* (2002). Education Week on the Web. Bethesda, MD: Editorial Projects in Education, Inc.

[10] *Quality Counts 2001: A Better Balance* (2001). Education Week on the Web. Bethesda, MD: Editorial Projects in Education, Inc.

[11] *Dispelling the Myth: High Poverty Schools Exceeding Expectations* (1999). Washington, DC: The Education Trust.

High Performing Schools

DEFINITION

High performing schools is the percentage of schools in Rhode Island that are categorized as high performing, defined as schools in which 50% or more of the students scored at or above standard on the *New Standards Reference Examinations* in Mathematics and English Language Arts and *The Rhode Island Writing Assessment.*

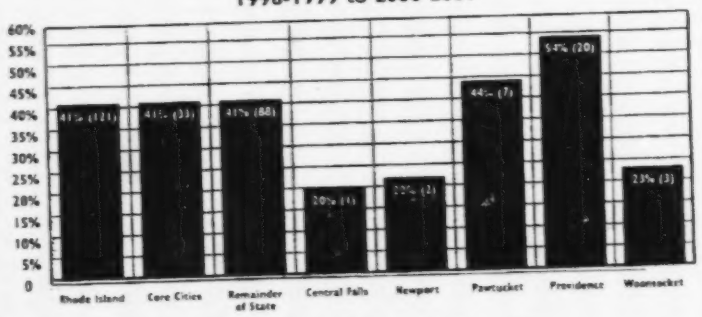
SIGNIFICANCE

Appropriate accountability systems that regularly measure student performance can improve instruction and student learning. Accountability standards make intended learning goals explicit and provide periodic feedback to parents, students, teachers, policymakers and the public.[1] It is important that performance assessments are consistent with the schools' content standards, specifying what teachers are supposed to teach and what students are expected to learn.[2,3]

Rhode Island has in place an accountability program which measures the performance of students on statewide tests in every school in the areas of math, reading, writing, and health. Schools in which 50% or more of the students achieve the state standards in reading writing and math are classified as high performing; schools in which 33% or more of the students score significantly below standards or do not take the test are classified as low performing; and schools that fall between these two categories are considered moderately performing.[4,5]

The first results of Rhode Island's new accountability system were released in February 2002. While 35% of schools in Rhode Island were categorized as high performing, only 4% of schools in the core cities were high performing and 91% were low performing.[6] However, almost half of all schools in Rhode Island and the core cities had improved between the 1998-1999 and 2000-2001 school years. School districts are required to respond to performance evaluations in their Strategic Plans by May 1, 2002. The Rhode Island Department of Elementary and Secondary Education will be meeting with school districts to design individualized plans for improvement based on performance results.[7]

Schools Showing Improvement, Rhode Island and Core Cities, 1998-1999 to 2000-2001



Source: Rhode Island Department of Elementary and Secondary Education, February 2002.

◇ Improvement in performance is an important measure and one which is particularly critical for schools serving low-income students who start out with multiple disadvantages.[8] In the core cities, 41% of schools showed improvement between 1998-1999 and 2000-2001, comparable to progress in the remainder of state. Improvement ranged from 54% of schools in Providence to 20% in Central Falls.[9]

◇ To be classified as improving, Rhode Island schools must both increase the percentage of children meeting standards in math or reading/writing and must decrease the percentage of children falling into the low performance range in the same area of testing.[10,11]

◇ National research indicates that schools serving low-income students can achieve standards for high performance. These high performing schools use state standards to inform curriculum design; evaluate both students and teachers based on state standards; spend more time on the basics of reading and math; invest in professional development; closely monitor individual student progress and provide additional supports immediately when students are struggling; and involve parents.[12]

Source: Rhode Island Department of Elementary and Secondary Education, 1998-2001. See methodology on page 124 for more information on the definition of improving schools.

School Performance, Rhode Island, District Profile 2002

Table 33

DISTRICT	TOTAL # OF SCHOOLS	PERFORMANCE CATEGORY			ND DATA	% HIGH PERFORMING SCHOOLS	% LOW PERFORMING SCHOOLS
		HIGH	MODERATE	LOW			
Barrington	6	4	2	0	0	67%	0%
Bristol-Warren	9	1	1	3	4	20%	60%
Burrillville	5	1	2	1	1	25%	25%
Central Falls	8	0	0	5	3	0%	100%
Chariho	7	4	1	2	0	57%	29%
Coventry	8	3	4	1	0	38%	13%
Cranston	24	12	6	6	0	50%	25%
Cumberland	10	2	4	2	2	25%	25%
East Greenwich	6	4	2	0	0	67%	0%
East Providence	16	2	5	6	3	15%	46%
Exeter-W. Greenwich	5	1	2	0	2	33%	0%
Foster	1	1	0	0	0	100%	0%
Foster-Glocester	2	0	2	0	0	0%	0%
Glocester	2	2	0	0	0	100%	0%
Jamestown	2	2	0	0	0	100%	0%
Johnston	9	2	4	2	1	25%	25%
Lincoln	7	3	3	0	1	50%	0%
Little Compton	2	2	0	0	0	100%	0%
Middletown	6	2	2	1	1	40%	20%
Narragansett	3	2	0	1	0	67%	33%
New Shoreham	3	1	2	0	0	33%	0%
Newport	9	2	1	6	0	22%	67%
North Kingstown	10	7	2	0	1	78%	0%
North Providence	12	2	8	2	0	17%	17%
North Smithfield	5	1	3	0	1	25%	0%
Pawtucket	16	0	1	15	0	0%	94%
Portsmouth	6	3	2	0	1	60%	0%
Providence	54	1	0	36	17	3%	97%
Scituate	5	5	0	0	0	100%	0%
Smithfield	6	4	2	0	0	67%	0%
South Kingstown	10	6	1	0	3	86%	0%
Tiverton	6	4	1	1	0	67%	17%
Warwick	27	13	9	5	0	48%	19%
West Warwick	6	2	1	3	0	33%	50%
Westerly	7	3	3	1	0	43%	14%
Woonsocket	14	0	2	11	1	0%	85%
**State-run schools*	*2*	*0*	*0*	*1*	*1*	*0%*	*100%*
**Charter schools*	*3*	*0*	*0*	*2*	*1*	*0%*	*100%*
Core Cities	*101*	*3*	*4*	*73*	*21*	*4%*	*91%*
Remainder of State	*238*	*101*	*74*	*40*	*23*	*47%*	*19%*
Rhode Island	*339*	*104*	*78*	*113*	*44*	*35%*	*38%*

**State-run schools are Rhode Island School for the Deaf and Dasher Career Technical. Charter schools are Metropolitan Career & Technical Center, The Urban Collaborative, and Highlander Charter School.*

Source of Data for Table/Methodology

All data are from the Rhode Island Department of Elementary and Secondary Education, using three years of test data: 1999, 2000, and 2001. In several communities, one school building may house primary, junior high and/or high school grades. For purposes of this table they are reported as separate schools.

The denominator is the total number of categorized schools in each school district and does not include schools that were not categorized because they lack a testable grade level or are new schools without adequate years of data (no data schools).

High performing schools are those in which at least 50% of students achieved the standard; low performing schools are those in which 33% or more of students performed significantly below standards or did not score; moderately performing schools are those that do not fall into high or low performing categories.

References for Indicator

[1,2,3] Linn, R. (April 2001). *The Design and Evaluation of Educational Assessment and Accountability Systems* (CSE Technical Report 539). Los Angeles, CA: Center for the Study of Evaluation, National Center for Research on Evaluation, Standards, and Student Testing, University of California, Los Angeles.

[3] Briars, D. (August 2000). *Standards, Assessments—and What Else? The Essential Elements of Standards-Based School Improvement.* CSE Technical Report 528). Los Angeles, CA: Center for the Study of Evaluation, National Center for Research on Evaluation, Standards, and Student Testing, University of California, Los Angeles.

[4,5,6] *School Performance Categories, Technical Assistance Bulletin #1* (February 2002). Providence, RI: Rhode Island Department of Elementary and Secondary Education.

[5,6] *Implementation of Federal Education Reform in the Ocean State* (A Special Bulletin of the Rhode Island Public Expenditure Council) (January 25, 2002). Providence, RI: Rhode Island Public Expenditure Council.

[6] Rhode Island Department of Elementary and Secondary Education, School Performance Categories, District Profile 1998-2001.

[7] *Dispelling the Myth: High Poverty Schools Exceeding Expectations* (1999). Washington, DC: The Education Trust.

High School Graduation Rate

DEFINITION

High school graduation rate is the percentage of the ninth-grade class that is expected to graduate, based on the existing drop-out incidence among 9th, 10th, 11th, and 12th grade students. The rate is computed using fall enrollment data and the number of students who dropped out between October 2, 1999 and October 1, 2000. It is a four-year cumulative rate, and represents the probability of an individual student graduating from high school.

SIGNIFICANCE

Children who receive a quality education are more likely to grow into capable, productive adults who contribute to their communities. Student achievement and graduation rates can be improved when schools have high expectations for all students, have effective and up-to-date curricula and teaching methods, prepared and sufficiently supported teachers, strong home/school linkages, adequate accountability systems, and effective and equitable allocation of resources.[1] Students can benefit from access to a broad range of community and school supports that address academic issues, health problems, inadequate nutrition, neighborhood and family violence, and other factors that can disrupt school performance.[2]

During the 2000-2001 school year, 2,201 Rhode Island youths dropped out of public school.[3] Young adults from the poorest twenty percent of U.S. families are six times more likely to drop out of high school as young adults from the wealthiest twenty percent of families.[4,5]

Youths who drop out of school are more likely to rely on public assistance as adults.[6] In 1999, over half of the people over 25 who did not have a high school diploma or GED reported no earnings during that year.[7] People without a high school diploma who found employment earned a median income of $11,606 compared to $19,979 for people with a high school degree or GED.[8] Young women who drop out of school are more likely to be poor, to have children at younger ages, and to be single parents than high school graduates.[9,10]

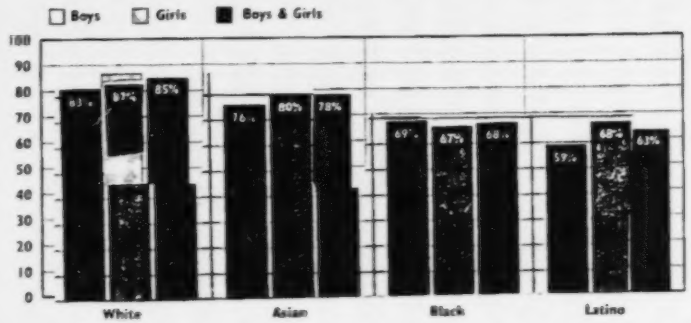
Percent of Teens Who Are High School Dropouts
(teens ages 16-19)

	1990	2000
RI	13%	10%
US	12%	11%
State Rank		*22nd*

1st is best; 50th is worst

Source: *Children at Risk: State Trends 1990-2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

High School Graduation Rate, by Race/Ethnicity and Gender, Rhode Island, 2000-2001



◇The high school graduation rate for Latino boys (59%) is the lowest of any other racial or ethnic group in Rhode Island. Nearly 2 in 5 Hispanic boys and 1 in 3 Hispanic girls drop out of high school.[11]

Source: Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

Latino Students in Rhode Island

◇ Rhode Island has 35,000 Latino children and youths, about 14% of the total children and youth population in the state. Of all the Latino youth living in the state, 85% live in the five core cities of Providence, Pawtucket, Woonsocket, Newport and Central Falls.[12]

◇ The Hispanic population in Rhode Island is growing. The Census reports the Rhode Island Hispanic population in 1995 was 60,000 with a 2025 projection of 176,000, a nearly 200% increase.[13]

◇ Compared to students of other racial/ethnic groups, Latino high school students have the lowest achievement ratings in math, reading and writing.[14]

School Attendance

DEFINITION

School attendance is the average daily attendance rate of public school students in each school district in Rhode Island for elementary school (grades 1-5), middle school (grades 6-8), and high school (grades 9-12). Public school students in pre-school, kindergarten, and ungraded classrooms are not included.

SIGNIFICANCE

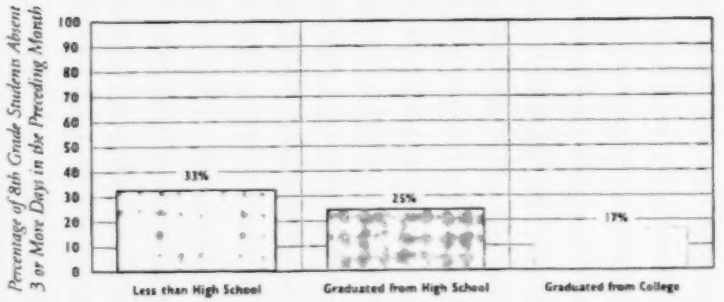
Poor school attendance affects school achievement for young children as well as teenagers. Younger children miss the opportunity to develop important academic skills and to make connections with peers and teachers. Lower attendance rates are linked to lower reading scores and are an important factor in variation in states' mathematics scores.[1,2] Absenteeism is detrimental to student achievement. Students who miss school fall behind their peers in the classroom, increasing the likelihood that they will drop out of high school.[3]

Problems with student attendance create a climate of instability in schools. In schools where truancy rates are low, there is less disruption and violence. Teachers are more committed to students and are more likely to interact and engage with the entire class. Students are less likely to miss school when they are engaged and have a sense of belonging due to established relationships with both their teachers and classmates.[4]

Truancy is rarely a reflection of the child alone and is often the first indication that the family needs help.[5] Children miss school for a variety of reasons. Instability at home resulting from frequent residential moves and family crisis or a parent's illness often contributes to poor attendance.[6] Teens report that a sense of failure, alienation from school, irrelevant courses and suspensions are involved in their decisions to skip school.[7] Poor attendance may also signal drug use, emotional and mental health problems, and peer pressure to miss school.[8] Truancy among teens is a powerful predictor of juvenile delinquency and may be connected with substance abuse and other illegal activities.[9,10]

In Rhode Island during the 2000-2001 school year, high school attendance rates were 85% in the core cities and 92% in the remainder of state.[11] With 11,401 high school students in the core cities, improving the core cities' high school attendance rate from 85% to 92% would mean that 800 more students would be attending high school in the core cities each day of the school year.

School Absenteeism Among 8th Grade Students, by Parent's Education Level, United States, 1998



◇ School absences are higher, on average, for students whose parents are less educated. In the U.S., eighth-grade students whose better-educated parent had less than a high school education were the most likely to have excessive absences. Students whose better-educated parent had graduated from college were the least likely to have excessive absences.

◇ Student attendance varies by race and ethnicity. Nationally, Hispanic and Native American students are most likely to have excessive absenteeism while Asian students are the least likely to have excessive absences. In 1998, 34% of Native American 8th graders missed 3 or more days of school in the month preceding the survey, followed by Hispanic students (25%), Black students (23%), White students (21%) and Asian students (17%).

Source: *Trends in the Well Being of America's Children and Youth* (2000). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

School Attendance Rates, Rhode Island, 2000-2001

Table 34

SCHOOL DISTRICT	# ENROLLED ELEMENTARY SCHOOL	ATTENDANCE RATE	# ENROLLED MIDDLE SCHOOL	ATTENDANCE RATE	# ENROLLED HIGH SCHOOL	ATTENDANCE RATE
Barrington	1,333	96%	751	96%	944	94%
Bristol-Warren	1,466	95%	905	93%	1,151	90%
Burrillville	1,000	96%	670	94%	897	92%
Central Falls	1,556	94%	825	91%	853	86%
Chariho	1,476	95%	967	95%	1,117	93%
Coventry	2,149	97%	1,362	95%	1,720	90%
Cranston	4,424	96%	2,667	93%	2,985	89%
Cumberland	2,047	96%	1,288	95%	1,422	92%
East Greenwich	986	96%	598	96%	648	95%
East Providence	2,608	95%	1,634	93%	1,936	87%
Exeter-W. Greenwich	810	96%	553	96%	618	93%
Foster	373	95%	NA	NA	NA	NA
Foster-Glocester	NA	NA	692	94%	876	91%
Glocester	720	96%	NA	NA	NA	NA
Jamestown	342	96%	208	97%	180	92%
Johnston	1,390	95%	844	92%	845	87%
Lincoln	1,472	96%	915	95%	1,054	93%
Little Compton	194	94%	118	95%	102	90%
Middletown	1,082	96%	562	95%	733	92%
Narragansett	689	96%	437	95%	545	93%
New Shoreham	60	92%	22	91%	76	91%
Newport	1,193	94%	598	91%	772	89%
North Kingstown	1,779	96%	1,034	95%	1,171	91%
North Providence	1,364	96%	971	95%	918	93%
North Smithfield	756	96%	433	96%	489	94%
Pawtucket	4,388	95%	2,600	93%	2,224	87%
Portsmouth	1,153	96%	701	95%	829	95%
Providence	11,392	91%	5,813	87%	5,764	82%
Scituate	705	96%	414	95%	535	94%
Smithfield	1,051	96%	671	95%	799	92%
South Kingstown	1,670	96%	1,029	95%	1,311	93%
Tiverton	827	95%	584	94%	613	91%
Warwick	4,580	96%	3,040	94%	3,711	92%
West Warwick	1,506	95%	938	93%	1,140	89%
Westerly	1,429	96%	853	94%	1,063	94%
Woonsocket	2,784	94%	1,329	92%	1,788	87%
Core Cities	*21,313*	*93%*	*11,165*	*90%*	*11,401*	*85%*
Remainder of State	*41,441*	*96%*	*25,861*	*94%*	*30,428*	*92%*
Rhode Island	*62,754*	*95%*	*37,026*	*93%*	*41,829*	*90%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the total number of students enrolled in the school district.

References for Indicator

[*] *A Report from the Kids Mobility Project* (March 1998). Minneapolis: The Kids Mobility Project.

[†] "Indicator 42: Student Absenteeism and Tardiness" (1996). *The Condition of Education*. Washington, DC: National Center for Education Statistics.

[‡] "Student Truancy." *ERIC Digest*, Number 125 (1999). Eugene OR: ERIC Clearinghouse on Educational Management.

[§] *Urban Policies and Programs to Reduce Truancy* (1997). Clearinghouse on Urban Education, ERIC DIGEST.

[¶] *Truancy, Literacy and the Courts, A User's Manual For Setting Up a Truancy Intervention Program* (2001). Washington, DC: The American Bar Association.

[**] *Manual to Combat Truancy: The Problem of Truancy in America's Communities* (July 1996). Washington, DC: U.S. Department of Education and U.S. Department of Justice.

[††] Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

Suspensions

DEFINITION

Suspensions is the rate of infractions and disciplinary actions per 100 students in kindergarten through twelfth grade in Rhode Island public schools. Disciplinary actions include in-school suspensions, out-of-school suspensions, and alternative program placements. Data are for the 2000-2001 school year.

SIGNIFICANCE

Effective school discipline strategies focus on ensuring the safety of students and staff, encouraging responsible behavior, and creating an environment conducive to learning.[1] During the 2000-2001 school year, 17,627 of Rhode Island's 157,269 students were suspended. This is a rate of 29.4 disciplinary actions per 100 students.[2] The most common discipline problems in schools involve non-criminal student behavior that is disruptive of the learning environment.[3] Almost two-thirds of the 46,161 infractions resulting in disciplinary action in Rhode Island were minor offenses including skipping class, skipping detention, tardiness and other minor offenses as determined by each school districts' policies.[4] Possession of drugs or weapons accounted for 803 disciplinary actions, approximately 2% of all infractions.[5]

Schools may take any number of actions when a student is disruptive, interferes with the learning of other students, or affects the safety of others. Research shows that the best approach to school discipline is a balance between clearly communicated and consistently enforced rules and a climate of concern for students as individuals. Smaller schools – or larger schools divided into "schools within schools" – are better able to address the individual needs of students.[6] Students who dislike school, do poorly academically, and have limited career objectives are more likely to be disruptive.[7,8] Students with discipline problems have lower test scores and are more likely to drop out of school.[9,10]

During the 2000-2001 school year, 26% of the suspensions in Rhode Island public schools were linked to students enrolled in special education.[11] Suspension of students with Individual Education Plans varies widely across school districts, from as high as 48% of all suspensions to a low of 11%.[12] Minority children and poor children in Rhode Island are also more likely to be suspended.[13,14] The Task Force on Racial Bias and School Discipline, created by the Rhode Island House of Representatives, concluded in its interim report that there is evidence that both race and economic status are factors in school suspensions. The Task Force reported that as many as one-third of Rhode Island schools show an over-representation of minorities in suspension data.[15]

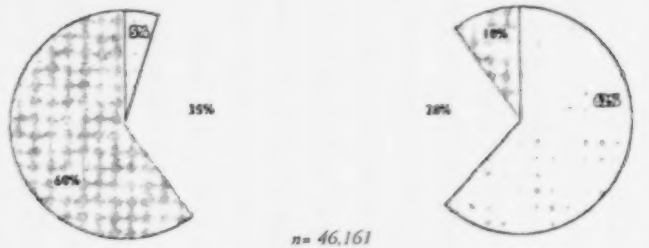
Disciplinary Actions, Rhode Island Public Schools, 2000-2001

By Grade Level

5%	Elementary School (K-5)
35%	Middle School (6-8)
60%	High School (9-12)

By Category

62%	Out-of-School Suspensions
28%	In-School Suspensions
10%	Alternative Program Placement



n= 46,161

◇ During the 2000-2001 school year, there were 46,161 incidents in which a Rhode Island public school student received a suspension or alternative program placement. Almost two-thirds of the disciplinary actions were out-of-school suspensions. The 46,161 suspensions can be attributed to 17,627 students.

By Type of Infraction	Number	Percent
Minor Offenses*	29,469	64%
Disorderly Conduct	8,328	18%
Fighting	3,106	7%
Assault	1,528	3%
Threat/Intimidation	1,203	3%
Possession or Use of Tobacco	1,005	2%
Drug Offenses	513	1%
Larceny/Theft	387	<1%
Vandalism	291	<1%
Weapon Possession	290	<1%
Missing Data/Unknown	41	<1%
Total	*46,161*	*100%*

*Examples of minor offenses includes cutting class, skipping detention and tardiness.

Source: Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

Table 35.

Disciplinary Actions, Rhode Island School Districts, 2000-2001

SCHOOL DISTRICT	# OF STUDENTS ENROLLED	TYPE OF DISCIPLINARY ACTION: SUSPENDED OUT-OF-SCHOOL	SUSPENDED IN-SCHOOL	ALTERNATE PROGRAM PLACEMENT	TOTAL DISCIPLINARY ACTIONS	RATE PER 100 STUDENTS
Barrington	3,241	97	13	0	110	3.4
Bristol-Warren	3,792	945	653	0	1,598	42.1
Burrillville	2,820	355	389	37	781	27.7
Central Falls	3,489	744	392	2	1,138	32.6
Chariho	3,909	556	1,564	106	2,226	56.9
Coventry	5,730	1,005	22	22	1,049	18.3
Cranston	11,040	2,693	0	0	2,693	24.4
Cumberland	5,244	376	32	0	408	7.8
East Greenwich	2,406	226	271	3	500	20.8
East Providence	6,605	591	9	0	600	9.1
Exeter-W. Greenwich	2,135	280	24	0	304	14.2
Foster	411	0	0	0	0	0.0
Foster-Glocester	1,597	351	0	0	351	22.0
Glocester	843	4	0	0	4	0.5
Jamestown	645	2	0	0	2	0.3
Johnston	3,492	776	0	0	776	22.2
Lincoln	3,645	499	345	185	1,029	28.2
Little Compton	341	3	0	0	3	0.9
Middletown	2,817	488	740	1	1,229	43.6
Narragansett	1,782	216	113	1	330	18.5
New Shoreham	130	4	3	0	7	5.4
Newport	3,041	768	12	7	787	25.9
North Kingstown	4,486	483	56	0	539	12.0
North Providence	3,549	355	559	0	914	25.8
North Smithfield	1,852	279	0	0	279	15.1
Pawtucket	10,069	1,528	68	1	1,597	15.9
Portsmouth	2,869	58	20	1,188	1,266	44.1
Providence	26,859	6,258	4,006	2	10,266	38.2
Scituate	1,709	86	262	0	348	20.4
Smithfield	2,704	247	1	3	251	9.3
South Kingstown	4,328	662	72	22	756	17.5
Tiverton	2,201	316	1,625	9	1,950	88.6
Warwick	12,265	3,438	9	2,403	5,850	47.7
West Warwick	3,736	1,030	1,046	0	2,076	55.6
Westerly	3,659	254	0	0	254	6.9
Woonsocket	6,756	2,205	750	683	3,638	53.8
State-Operated	1,072	251	1	0	252	23.5
Core Cities	*50,214*	*11,503*	*5,228*	*695*	*17,426*	*34.7*
Remainder of State	*107,055*	*16,926*	*7,829*	*3,980*	*28,735*	*26.8*
Rhode Island	*157,269*	*28,429*	*13,057*	*4,675*	*46,161*	*29.4*

Notes to Table

Suspension rate per 100 students is based on the total disciplinary actions for the school district at all grade levels. The denominator is the total number of students enrolled in kindergarten through 12th grade in the school district.

Total disciplinary actions is the number of incidents resulting in suspension - either in-school or out-of-school, or placement of the student in an alternate program. It does not reflect the total number of students disciplined because each student can receive more than one disciplinary action during the school year.

Expulsion can no longer be reported as a separate category because under Rhode Island law schools cannot expel students. Therefore, expulsions are included in the out-of-school suspension category.

Suspension policies vary by district. The type of infraction resulting in disciplinary action varies according to school district policy. The type of disciplinary action used for each type of infraction also varies according to school district policy.

State operated schools are the Rhode Island School for the Deaf, Davies Career Technical School, and Metropolitan Career Technical Center.

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

References for Indicator

[1997] Grunzel, J. (1992). School Discipline. Eugene, OR: ERIC Clearinghouse on Educational Management. ERIC Digest, Number 78.

[1999/2000] Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

[1997] *Order in the Classroom* (October 1998). Princeton, NJ: Educational Testing Center, Policy Information Center, Research Division.

[1998] *The Condition of Education 1997* (1998). Washington, DC: National Center for Education Statistics.

[2000] *Interim Report of the Task Force on Racial Bias and School Discipline* (2002). Providence, RI: Rhode Island Department of Secondary and Elementary Education.

[2000] "Blacks are suspended more often, report says" *Providence Journal* (June 15, 2000). Providence, RI and "Discipline: Suspension rates vary widely among schools" *Providence Journal* (June 17, 2001). Providence, Rhode Island.

Table 36

High School Graduation Rate, Rhode Island, 2001

SCHOOL DISTRICT	COMMUNITY CONTEXT						2001 GRADUATION RATE
	% CHILDREN IN POVERTY	% ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% LIMITED ENGLISH PROFICIENCY	% MINORITY ENROLLMENT	% OF STUDENTS TAKING THE SAT	
Barrington	2.3%	89%	3,241	1%	3%	78%	91%
Bristol-Warren	13.6%	NA	3,792	3%	3%	57%	72%
Burrillville	7.0%	71%	2,820	0%	2%	57%	77%
Central Falls	35.7%	47%	3,489	30%	72%	36%	67%
Chariho	8.7%	82%	3,909	0%	3%	53%	89%
Coventry	7.5%	74%	5,730	0%	4%	47%	92%
Cranston	10.9%	74%	11,040	4%	15%	57%	81%
Cumberland	4.8%	75%	5,244	3%	5%	69%	93%
East Greenwich	3.7%	90%	2,406	1%	6%	83%	90%
East Providence	9.7%	67%	6,605	6%	17%	54%	78%
Exeter-W. Greenwich	6.5%	78%	2,135	0%	3%	62%	97%
Foster	11.3%	82%	411	0%	3%	NA	NA
Foster-Glocester	8.3%	83%	1,597	0%	2%	60%	91%
Glocester	10.8%	83%	843	0%	2%	NA	NA
Jamestown	10.3%	89%	645	0%	3%	NA	NA
Johnston	10.0%	67%	3,492	2%	7%	65%	93%
Lincoln	9.5%	76%	3,645	1%	6%	71%	90%
Little Compton	3.5%	86%	341	0%	0%	NA	NA
Middletown	6.8%	85%	2,817	2%	14%	64%	90%
Narragansett	7.8%	87%	1,782	1%	5%	74%	96%
Newport	22.1%	84%	3,041	3%	36%	70%	77%
New Shoreham	9.5%	94%	130	2%	5%	71%	100%
North Kingstown	6.9%	86%	4,486	1%	6%	73%	88%
North Providence	7.4%	71%	3,549	3%	12%	45%	89%
North Smithfield	1.4%	72%	1,852	0%	2%	64%	95%
Pawtucket	17.6%	62%	10,069	12%	44%	50%	63%
Portsmouth	6.0%	86%	2,869	0%	4%	80%	94%
Providence	40.9%	63%	26,859	21%	82%	77%	64%
Scituate	5.3%	84%	1,709	0%	2%	69%	93%
Smithfield	4.5%	81%	2,704	0%	2%	70%	91%
South Kingstown	9.0%	86%	4,328	1%	11%	84%	85%
Tiverton	8.5%	71%	2,201	0%	1%	74%	89%
Warwick	9.0%	78%	12,265	1%	5%	65%	91%
Westerly	9.6%	76%	3,659	1%	6%	59%	90%
West Warwick	16.7%	70%	3,736	2%	11%	54%	72%
Woonsocket	22.3%	56%	6,756	6%	35%	49%	78%
Core Cities	*31.4%*	*NA*	*50,214*	*17%*	*65%*	*63%*	*NA*
Remainder of State	*8.5%*	*NA*	*105,983*	*2%*	*7%*	*62%*	*NA*
Rhode Island	*15.8%*	*72%*	*156,197*	*6%*	*26%*	*62%*	*81%*

Source of Data for Table/Methodology

% children in poverty is from the U.S. Bureau of the Census, Small Area Income and Population Estimates, Children Ages 5-17, 1997, released in November 2000. Percent of adults is from the 1990 Census of the Population. All other data are from the Rhode Island Department of Elementary and Secondary Education, 2000-2001 school year.

The denominator for the indicator is the number of children enrolled in 9th, 10th, 11th, and 12th grades in the fall of 2000. NA: Community has a regional high school.

References

[1] *Years of Promise: A Comprehensive Learning Strategy for America's Children* (1996). New York, NY: Carnegie Corporation of New York.

[2] *KIDS COUNT Data Book: State Profiles of Child Well-Being* (1997). Baltimore, MD: The Annie E. Casey Foundation.

[3] [4] [5] [6] Rhode Island Department of Elementary and Secondary Education, 2000-2001 and 1998-2000.

[7] Haycock, K. and Huang, S. (Winter 2001). "Are Today's High School Graduates Ready?" in *Thinking K-16*, Vol. 5, No. 1. The Education Trust.

[8] [9] *Dropout Rates in the United States: 2000* (2001). Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement, National Center for Education Statistics.

[10] Brown, B. (August 2001). *Teens, Jobs, and Welfare: Implications for Social Policy*. Washington, DC: Child Trends.

[11] Greene, J. (November 2001). *High School Graduation Rates in the United States*. New York, NY: Black Alliance for Educational Options and the Center for Civic Innovation at the Manhattan Institute.

[12] U.S. Bureau of the Census. *Income in 1999 by Educational Attainment for People 18 Years Old and Over, by Age, Sex, Race, and Hispanic Origin: March 2000*.

[13] Phillips, L. (1998). *The Girls Report: What We Know and Need to Know About Growing Up Female*. New York, NY: National Council for Research on Women.

[14] U.S. Bureau of the Census, 2000 Census of the Population.

[15] U.S. Bureau of the Census, *Projected State Populations by Sex, Race, and Hispanic Origin: 1995-2025*.

Teens Not in School and Not Working

DEFINITION

Teens not in school and not working is the percentage of teens ages 16 to 19 who are not enrolled in school, not in the Armed Forces, and not employed. This indicator includes recent high school graduates who are unemployed, and teens who have dropped out of high school and are jobless.

SIGNIFICANCE

In 2000, 7% of Rhode Island teens ages 16 to 19 were neither enrolled in school nor working. Dropping out of school and not becoming part of the workforce places these 4,000 teens at a significant disadvantage as they transition from adolescence to adulthood.[1] These adolescents have a difficult time getting connected to the job market as young adults and have a less stable employment history than their peers who stayed in school or secured jobs.[2,3] They are also at an especially high risk for teen parenting, crime and negative behaviors.[4,5] These youth risk facing limited economic prospects and an increased risk of being dependent on public assistance.[6,7]

Many school and community programs do not adequately address the needs of students on the verge of dropping out of school and out-of-school youth.[8] All youth need opportunities to develop basic skills such as math, reading and writing. They also need to develop qualities that will help them to find a job, including problem solving, creativity, self-motivation, and responsibility.[9] An increasing number of new jobs are available only to those with higher skill levels. Between 2002 and 2008, nearly 1 in 4 jobs will require at least a bachelor's degree, and 70% of the fastest-growing jobs will require at least some postsecondary education.[10,11]

For those likely to drop out of school with no connection to the job market, school-linked, part-time jobs can be an important resource to prevent dropping-out, reinforce learning in school, and develop positive work attitudes and habits.[12]

Teens Not In School and Not Working

	1990	2000
RI	10%	7%
US	10%	9%
State Rank		*12th*

1st is best; 50th is worst

Source: *Children at Risk: State Trends 1990-2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Out-of-School Youth: National Trends

◇ The percentage of Black and Hispanic youth ages 16 to 19 who are neither employed nor in school exceeds that of White youth. In 2000, 13% of Black youth, 13% of Hispanic youth, and 6% of White youth were neither in school nor employed.[13]

◇ Females are more likely than males to be neither employed nor in school. In 2000, 9% of girls and 7% of boys ages 16 to 19 were neither attending school nor working.[14]

The Rhode Island Truancy Court

◇ Truancy is one of the early warning signs of potential delinquent activity, including dropping out of school. Intervention in schools is an effective strategy for reducing truancy and increasing graduation rates.

◇ The Rhode Island Truancy Court was established in September of 1999. As a department of Rhode Island Family Court, the Truancy Court serves as a community and school-based intervention program for truant students and their families.

◇ The court serves about 20 middle schools and high schools in Providence, Pawtucket, Central Falls, Woonsocket, Cranston, Newport, Warwick, West Warwick, Bristol/Warren, and Smithfield (including Johnston and Foster/Glocester).

◇ The Truancy Court assigns a magistrate to hear cases at a school-based courtroom on a weekly basis. After a hearing with parents and truant students, the court mandates appropriate intervention measures such as counseling, tutoring and social services. The court supervises cases until truancy is no longer an issue.

◇ During the court's first year, 193 students participated, most between the ages of 13 and 14. The average rate of attendance for the middle school students before intervention was 49%. After intervention and at the end of the 1999-2000 school year, the average rate of attendance was 89%.

Sources: National Truancy Reduction Demonstration Program; Rhode Island Family Court, Truancy Court.

Table 37. **% Teens Not in School and Not Working, Ages 16-19, Rhode Island, 1990**

CITY/TOWN	TOTAL NUMBER OF TEENS AGES 16-19	JOBLESS HIGH SCHOOL GRADUATES	JOBLESS NON-HIGH SCHOOL GRADUATES	TOTAL NUMBER OF JOBLESS TEENS	% OF TEENS WHO ARE JOBLESS
Barrington	800	8	17	25	3.1%
Bristol	1,703	43	34	77	4.5%
Burrillville	886	33	31	64	7.2%
Central Falls	931	35	100	135	14.5%
Charlestown	261	0	0	0	0.0%
Coventry	1,689	59	52	111	6.6%
Cranston	3,500	119	304	423	12.1%
Cumberland	1,474	59	128	187	12.7%
East Greenwich	627	0	7	7	1.1%
East Providence	2,408	72	180	252	10.5%
Exeter	279	16	17	33	11.8%
Foster	232	16	3	19	8.2%
Glocester	565	27	27	54	9.6%
Hopkinton	377	10	44	54	14.3%
Jamestown	226	0	10	10	4.4%
Johnston	1,235	13	30	43	3.5%
Lincoln	874	32	17	49	5.6%
Little Compton	167	0	4	4	2.4%
Middletown	922	20	27	47	5.1%
Narragansett	653	15	16	31	4.7%
Newport	1,978	56	46	102	5.2%
New Shoreham	20	0	0	0	0.0%
North Kingstown	1,269	12	30	42	3.3%
North Providence	1,444	29	78	107	7.4%
North Smithfield	578	30	0	30	5.2%
Pawtucket	3,632	81	303	384	10.6%
Portsmouth	851	10	13	23	2.7%
Providence	12,841	254	1,042	1,296	10.1%
Richmond	284	18	16	34	12.0%
Scituate	555	24	10	34	6.1%
Smithfield	1,625	21	16	37	2.3%
South Kingstown	3,818	15	7	22	0.6%
Tiverton	812	34	24	58	7.1%
Warren	505	0	37	37	7.3%
Warwick	4,231	151	198	349	8.2%
Westerly	992	10	108	118	11.9%
West Greenwich	211	15	0	15	7.1%
West Warwick	1,478	46	89	135	9.1%
Woonsocket	2,357	101	285	386	16.4%
Core Cities	***21,739***	***527***	***1,776***	***2,303***	***10.6%***
Remainder of State	***37,551***	***957***	***1,574***	***2,531***	***6.7%***
Rhode Island	***59,290***	***1,484***	***3,350***	***4,834***	***8.1%***

Sources of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls

The denominator is the number of teens ages 16 to 19 according to the 1990 Census of the Population. Updated data from the 2000 Census was not available at the time of publication.

References for Indicator

[1] US Bureau of the Census, Current Population Survey, 1997 to 2001 average.

[2] [3] [4] *America's Children: Key National Indicators of Well-Being 2001* (2001). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[5] Lerman, R. I. (May 16, 1996). *Helping Disconnected Youth by Improving Linkages Between High Schools and Careers.* Presentation at the American Enterprise Institute Forum, America's Disconnected Youth: Toward a Preventative Strategy.

[6] Brown, B. (August 2001). *Teens, Jobs, and Welfare: Implications for Social Policy.* Washington, DC: Child Trends.

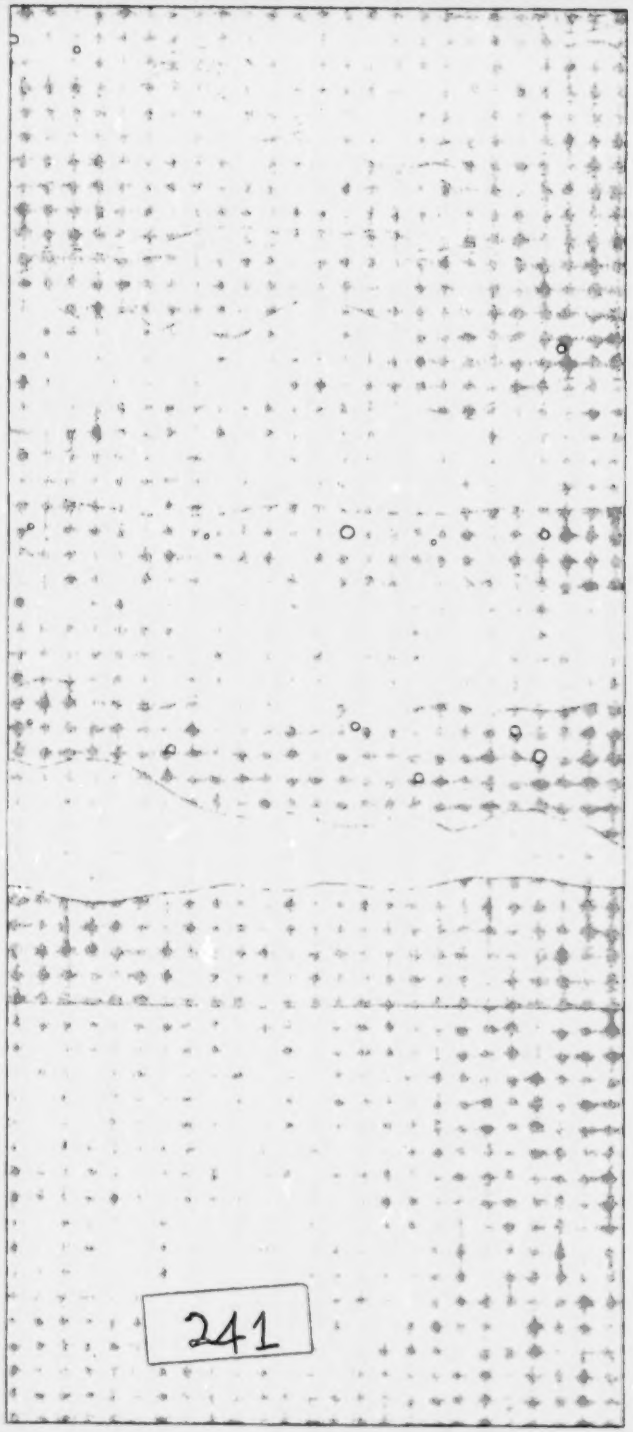
[7] Mroz, Thomas A. and Timothy H. Savage (October 2001). *The Long-Term Effects of Youth Unemployment.* Washington, DC: Employment Policies Institute.

[8] *Skills, Standards, and Entry Level Work: Elements of a Strategy for Youth Employment Development* (1995). Washington, DC: U.S. Department of Labor, Employment and Training Administration.

[9] *America's Promise: The Alliance for Youth* (1997). Five Resources All American Youth Need: How Are We Doing As a Nation. Minneapolis, MN: The Search Institute.

[10] Fleetwood, Chad and Kristina Shelly (Fall 2000). The Outlook for College Graduates, 1998-2008: A Balancing Act. *Occupational Outlook Quarterly*

[11] Haycock, Kati and Sandra Huang (Winter 2001). "Are Today's High School Graduates Ready?" in *Thinking K-16*, Vol. 5, No. 1. Washington, DC: The Education Trust.



241

Methodology and Acknowledgements

Methodology

The *2002 Rhode Island KIDS COUNT Factbook* examines 49 indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. The information on each indicator is organized as follows:

◇ ***Definition:*** A description of the indicator and what it measures.

◇ ***Significance:*** The relationship of the indicator to child and family well-being.

◇ ***Sidebars:*** Current state and national data and information related to the indicator.

◇ ***State Rank:*** For those indicators that are included in the Annie E. Casey Foundation's KIDS COUNT publications, the Factbook highlights Rhode Island's rank among the 50 states and trends since 1990. These data are from either the *2001 KIDS COUNT Data Book, Children At Risk: State Trends 1990 to 2000* or *The Right Start for America's Newborns: A Decade of City and State Trends (1990 - 1999).* Data from the three publications come from different data sources depending on the indicator. 2000 data used for state ranks are from the Population Reference Bureau, tabulation of data from the U.S. Census Bureau, Census 2000 Supplementary Survey (C2SS).

◇ ***City/Town Tables:*** Data for each indicator presented for each of Rhode Island's cities and towns, the state as a whole, and the core cities.

◇ ***Core Cities Data:*** Five core cities are identified based on high child poverty rates: Providence, Pawtucket, Woonsocket, Newport, and Central Falls. These are the only Rhode Island communities in which more than 15% of the children live below the poverty level, according to the 1990 Census.

◇ ***Most Recent Available Data:*** The 2002 Factbook uses the most current, reliable data available for each indicator.

◇ ***New Indicators:*** Six new indicators have been added to the 43 indicators included in the *2001 Rhode Island KIDS COUNT Factbook:* "Racial and Ethnic Diversity", "Breastfeeding", "Children with Special Needs", "Children with Incarcerated Parents", "Student Mobility" and "High Performing Schools."

The *2002 Rhode Island KIDS COUNT Factbook* presents the data for each indicator using numbers, rates, and/or percentages.

Numbers

The most direct measure of the scope of a problem is the count of the number of events of concern during a specified time period - e.g., the number of child deaths between 1996 and 2000.

Numbers are important in assessing the scope of the problem and in estimating the resources required to address a problem. Numbers are not useful to compare the severity of the problem from one geographic area to another or to compare the extent of the problem in your state with national standards. For example, a state with more children might have more low birthweight infants due to the larger number of total births, not due to an increased likelihood of being born low birthweight.

Rates and Percentages

A rate is a measure of the probability of an event - e.g., out of every 1,000 live births, how many infants will die before their first birthday.

A percentage is another measure of the probability of an event - e.g., out of every 100 births, how many will be born low birthweight.

Rates and percentages take into account the total population of children eligible for an event. They are useful in comparing the severity of the problem from one geographic area to another, to compare with state or national standards, or to look at trends over time.

Sources of Data and Methodology for Calculating Rates and Percentages

For each indicator, the source of information for the actual number of events of interest (the "numerator") are identified within the Source of Data/Methodology section next to the table for that indicator. For each indicator that uses a rate or a percent, the methodology used to estimate the total number of children eligible for the indicator of interest (i.e., the "denominator") is also noted within the Source of Data/Methodology section.

Rates and percentages were not calculated for cities and towns with small denominators (less than 500 for delayed prenatal care, low birthweight infants, and infant mortality rates and less than 100 for births to teens). Rates and percentages for small denominators are statistically unreliable. "NA" is noted in the indicator table when this occurs. In the indicator for child deaths and teen deaths, the indicator events are rare; in these instances, city and town rates are not calculated, as small numbers make these rates statistically unreliable.

Use of Census 2000 Data

Wherever possible data from Census 2000 was included in the 2002 Factbook. Census data will be released in phases over the next two years. Census data on age, race and ethnicity and household living arrangements has been released and is used in this edition of the Factbook. Most other household demographic data related to children will not be released until later in 2002. When Census 2000 data have been substituted in denominators, this was noted in the notes to the table. Caution should be taken when comparing new rates with past years as the population numbers used in the denominator have changed for all cities and towns. Otherwise, when Census 2000 data were not yet available, five year averages were used from the Current Population Survey as has been done in past Factbooks.

Methodology for Children Receiving Child Support Indicator

Estimated Number of Children in the Child Support Enforcement System: This number is higher than in previous years because it includes Rhode Island children for whom the Child Support Enforcement Office collects and disburses child support payments, regardless of whether or not the Child Support Enforcement Office is providing the family with services related to paternity establishment or child support enforcement.

Methodology for Infant and Preschool Child Care Indicator

Estimated Number of Children in Need of Regulated Care is computed by: 1) multiplying the Census 2000 number of children under age 6 by the 1990 percent of mothers in the workforce and multiplying this product by 47% (the 1990 percent of U.S. women with children under age 6 who used center-based care of family child care homes as their child care arrangement), adding this to 2) the number of 1 to 5 year olds living in families enrolled in FIP as of December 2001, multiplied by 50% (assuming half mothers work) and then multiplying by 75% (the percentage of families receiving child care subsidies that choose licensed child care centers as their child care arrangement). The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December 2001.

Methodology for Children Enrolled in Head Start

Estimated eligible children is based on a three-year average of 3 and 4 year old children in families receiving FIP at a single point in time during each of three years, 1996-1998. This is an underestimate of children eligible, because it does not include children eligible for Head Start who do not receive FIP but are living below the poverty line. Therefore, actual percentage eligible participating is likely to be lower than shown in the indicator.

Methodology for School-Age Child Care

School-based programs are school-age programs located in schools that may be administered through the school district or a community organization (for example YWCA, YMCA, etc.). Community-based programs are school-age child care programs located in the community, including child care centers, YMCA's, YWCA's, Boys and Girls Clubs and other community organizations. The numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 5 to 12 that do not require licensing by the state.

Methodology for Children Receiving Child Care Subsidies

The number of children receiving child care subsidies in a licensed child care center or a certified family child care home is the total number of children for whom the Rhode Island Department of Human Services paid a full or part-time subsidy as of December 2001. All data are based on the location of the child care program where the child receives services, not the residence of the child. Two child care programs, Child Care Connection and Child, Inc., have multiple centers and receive payment for all children at a central business office, not at the location of the center. For these programs, estimates were made on the number of subsidies attributed to centers by city or town either by licensed capacity or information provided by the centers on where children receiving child care subsidies are receiving services.

Estimated Number of Children under age 16 Eligible for Child Care Subsidies: The number of children under age 16 in working families under 185% of the Federal Poverty Level (FPL) is computed by: a) multiplying the 1990 Census number of women in the labor force with children under age 18 by the number of estimated total number of Rhode Island children under age 16 in 1990 from the U.S. Census, and b) the total number of children under age 16

continued, next page

with mothers in the workforce is multiplied by the percentage of children under 185% FPL (children eligible for free or reduced price school lunch) to get the estimated number of children under age 16 in working families under 185% of the FPL.

Methodology for Fourth Grade Reading Scores

As of 2000, the manner in which reading scores are calculated changed. In the past, a student was counted as a test taker only if they actually took the test and completed enough of it for a score to be calculated. As of 1999-2000, however, all students eligible to take the test are counted, whether or not they take the test or score. All students are eligible unless their IEP specifically exempts them or unless they are Beginning English Language Learners. As a result, overall proficiency rates, as reported here, are lower than they were under the previous system of scoring. For instance, in 1999, under the previous system of scoring, 84% of fourth graders were proficient in basic understanding and 69% in interpretation and analysis.

Methodology for High Performing Schools

A school is "improving" if between 1998-1999 and 2000-2001 there was at least a 3% increase in the percentage of students who demonstrate proficiency (in math and/or English language arts) and at least a 3% decrease in the percentage of students in the two lowest achievement levels plus "no score" category. These improvements must occur on 2 out of 3 math subtests and/or in 3 out of 4 English language arts subtests.

Limitations of the Data

In any data collection process there are always concerns about the accuracy and completeness of the data being collected. All data used in the 49 indicators were collected through the U.S. Bureau of the Census and through routine data collection systems operated by different agencies of the state of Rhode Island. We do not have estimates of the completeness of reporting to these systems.

In all cases, we used the most reliable data currently available. For census-based indicators, statewide numbers have been updated to 1999 using the Current Population Survey, 1997-2001 average. The Current Population Survey does not provide data at the level of city and town. City/town tables, therefore, use information from the 1990 Census of Population and 2000 Census data when available.

(continued from page 93)

References for Infant and Preschool Child Care

[10,17,18] Marshall, N. et al. (2001). *The Cost and Quality of Full Day, Year-round Early Care and Education in Massachusetts: Preschool Classrooms* (Executive Summary). Wellesley Centers for Women and Abt Associates Inc.

[11] Schumacher, R. et al (October 1999) *Child Care After Leaving Welfare: Early Evidence from State Studies.* Washington, DC: Center for Law and Social Policy.

[12] Shelton, E., et al (March 1999) *Parents' Views on Child Care and Child Care Assistance in the First Year of Statewide Welfare Reform: A Report to Children's Home Society of Minnesota.* Saint Paul, MN: Wilder Research Center.

[13] *Care Around the Clock: Developing Child Care Resources Before Nine and After Five.* (Executive Summary) (1995). Washington, D.C.: Women's Bureau, U.S. Department of Labor.

[14] Options for Working Parents (December 2001).

[15,16] Phillips, D. et al. (2001). Child Care and Our Youngest Children in *The Future of Children: Caring for Infants and Toddlers.* Spring/Summer 2001, Volume 11, Number 1. Los Altos, CA: The David and Lucile Packard Foundation.

[19] Larner, M. et al. (2001). Caring for Infants and Toddlers: Analysis and Recommendations in *The Future of Children: Caring for Infants and Toddlers.* Spring/Summer 2001, Volume 11, Number 1. Los Altos, CA: The David and Lucile Packard Foundation.

[20] *Building and Early Care and Education System in Rhode Island: KIDS COUNT Special Report* (1999). Providence, RI: Rhode Island KIDS COUNT.

Family Income Levels Based on the Federal Poverty Guidelines

Many federal programs use the federal poverty guidelines to determine whether or not families are eligible for services. Often, government assistance programs, including many of those administered by the state of Rhode Island, use 185% to 250% of the federal poverty line to determine income eligibility. The figures are adjusted upward for larger family sizes.

2001 Federal Poverty Level (FPL)	Annual Income Family of Three	Annual Income Family of Four
50% FPL	$7,315	$ 8,825
100% FPL	$14,630	$17,650
130% FPL	$19,019	$22,945
185% FPL	$27,066	$32,653
200% FPL	$29,260	$35,300
225% FPL	$32,918	$39,713
250% FPL	$36,575	$44,125

Source: 2001 Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services

Rhode Island KIDS COUNT Committees

Rhode Island State Agency Directors and Data Liaisons to KIDS COUNT

Robert Carl
Alvin Johnson
Department of Administration

Patricia Nolan, MD
Samara Viner-Brown
Department of Health

Jane Hayward
Sherry Campanelli
Randy Rosati
Department of Human Services

Peter McWalters
Dennis Cheek
Terry Bergner
Department of Elementary and Secondary Education

Lee Arnold
Linda Soderberg
Department of Labor and Training

Jay Lindgren
Leon Saunders
David Allenson
Department of Children, Youth and Families

Joseph E. Smith
Elizabeth Gilheeney
Governor's Justice Commission

Jeremiah S. Jeremiah, Jr.
David Heden
Family Court

A. Kathryn Power
Daniel McCarthy
Department of Mental Health, Retardation and Hospitals

Rhode Island KIDS COUNT Factbook Advisory Committee

Darlene Allen
Executive Director
Adoption Rhode Island

David Allenson
Senior Programmer Analyst
RI Department of Children, Youth and Families

Janet Anderson
Assistant Director
Children's Behavioral Health
RI Department of Children, Youth and Families

Christine Andrade
Case Worker
Tides Family Services

Thomas Anton, Ph.D.
Professor
A. Alfred Taubman Center for Public Policy
Brown University

Lenette Azzi-Lessing
Executive Director
Children's Friend & Service

Lee Baker
Family Preservation Coordinator
RI Department of Children, Youth and Families

Belinda Bermingham
Deputy Director
Urban League of Rhode Island

Vania Brown-Small
Minority Health Coordinator
RI Department of Health

Barbara Burgess
Early Childhood Education Specialist
RI Department of Elementary & Secondary Specialist

Mike Burk
Policy and Legislative Assistant
RI Department of Children, Youth and Families

Jean Burritt Robertson
Research Director
Rhode Island Economic Development Corporation

Sherry J. Campanelli
Associate Director
RI Department of Human Services

Victor Capellan
Facilitator, Parent Information and Registration Center
Providence Schools

Dennis Cheek
Director, Office of Information Services and Research
RI Department of Elementary & Secondary Education

Jack Combs
Research Administrator
A. Alfred Taubman Center for Public Policy, Brown University

Terese Curtin
Executive Director
Connecting for Children & Families

Laureen D'Ambra
State Child Advocate
Office of the Child Advocate

Virginia da Mota
Director, Office of Integrated Social Services
RI Department of Elementary & Secondary Education

Brenda Dann-Messier
Director
Dorcas Place Parent Literacy Center

Deborah DeBare
Executive Director
RI Coalition Against Domestic Violence

Elizabeth Earls
Executive Director
RI Council of Community Mental Health Centers

Myra J. Edens, RN
Director of Pediatric Patient Services
Rhode Island Hospital

William Flynn
Coordinator, Campaign to Eliminate Childhood Poverty
George Wiley Center

Joseph Garlick
Executive Director
Woonsocket Neighbo.hood Development Corp.

Nancy Gewirtz, Ph.D.
Director, Poverty Institute
Rhode Island College
School of Social Work

Elizabeth Gilheeney
Juvenile Justice Specialist
Governor's Justice Commission

Susanne Greschner
Senior Policy Analyst
RI Public Expenditure Council

Mary Sylvia Harrison
Executive Director
RI Children's Crusade for Higher Education

Blanche Higgins
Principal Planner
RI Department of Administration

David R. Heden
Chief Intake Supervisor
RI Family Court

Margaret Holland McDuff
Executive Director
Family Service, Inc.

William H. Hollinshead, MD
Medical Director
RI Department of Health
Division of Family Health

Senator Thomas Izzo
Rhode Island State Senate

Patricia Jaehnig
Assistant Coordinator
Justice and Peace Education
Diocese of Providence

continued, next page

Rhode Island KIDS COUNT Committees

Mitzie A. Johnson
Staff Supervisor
Parent Support Network

Linda Katz
Policy Director
The Poverty Institute at RI College
School of Social Work

Dennis B. Langley
Executive Director
Urban League of Rhode Island

Cathy Lewis
Team Leader
Casey Family Services

Peter Marino
Director of Policy
Rhode Island Public Expenditure Council

Patricia Martinez
Facilitator, Family and Community Partnerships
Providence School Department

Alexandra F. Moser
Executive Director
Diocesan Office of Child Care

Michael Msall, MD
Director, Child Development Center
Hasbro Children's Hospital

Robert Oberg
Director of Development
RI Children's Crusade

Maura O'Brien
Research Coordinator
Rhode Island Housing

Candace Powell
Director, Maternal Child Program
Visiting Nurse Services of Newport County

Elizabeth Priestley
Executive Director
RI Parent Information Network

Larry Pucciarelli
Head Start Collaboration Project Director
RI Department of Human Services

Peter Quattromani
Director of Policy
Governor's Office

Randy Rosati
Chief Human Services Policy & Systems Specialist
RI Department of Human Services

Hillary Salmons
Vice President for Program Development
Health and Education Leadership for Providence

Richard Scarpellino
Principal Deputy Clerk
Juvenile Intake Services
RI Family Court

Monica Schaberg, MD
Director of Pediatrics
Bradley Hospital

Rick Schwartz
Director of Communications
The Rhode Island Foundation

Kathleen M. Spangler
Executive Director
RI Department of Mental Health, Retardation & Hospitals

Reeva Sullivan Murphy
Child Care Administrator
RI Department of Human Services

Rosalind Vaz, MD
RI Hospital/Hasbro Children's Hospital

Samara Viner-Brown
Chief, Office of Data and Evaluation
RI Department of Health

Mao Yang
Public Policy and Research Associate
RI Coalition Against Domestic Violence

Rhode Island KIDS COUNT Community Leadership Council

Susan Adler Kaplan
Educational Consultant

Betsy Akin
March of Dimes

Darlene Allen
Adoption Rhode Island

Raymond Arsenault
Spurwink School

Robert Barge
Rhode Island Legal Services

Bernard Beaudreau
RI Community Food Bank

Adeline Becker
Education Alliance

Kate Begin
Prevent Child Abuse RI

Stanley Block, MD
Providence Community Health Centers, Inc.

Joyce Butler
Child Care Research Collaboration and Archive

Victor Capellan
Providence Schools

Sharon K. Carter
Newport Partnership for Families

Barbara Cavallaro
The Pawtucket Day Nursery Association

Michael Cerullo
Spurwink School

Brenda Clement
The Housing Network

Reverend E. Naomi Craig
Sheldon Street Church

Terese Curtin
Connecting for Children & Families

Brenda Dann-Messier
Dorcas Place Parent Literacy Center

Deborah DeBare
RI Coalition Against Domestic Violence

Robert DeBlois
Urban Collaborative Accelerated Program

Lynda Dickinson
CHILD, Inc.

Elizabeth V. Earls
RI Council of Community Mental Health Centers

John E. Farley, Jr., MD
Bradley Hospital

Louis Fazzano
Health and Education Leadership for Providence

Ruth Feder, Esq.
Office of Mental Health Advocate

Karen Feldman
Youth in Action

Dr. Robert Felner
National Center for Public Education and Social Policy
University of Rhode Island

Barbara Fields Karlin
LISC-Rhode Island

Maryann Finamore
West Bay Child Care

Patricia Flanagan, MD
Hasbro Children's Hospital

William Flynn
George Wiley Center

Amanda Frye-Leinhos
Martin Luther King Center

Rhode Island KIDS COUNT Committees

David Gagnon
National Perinatal Information Center

James Gannaway
Casey Family Services

Joseph Garlick
Woonsocket Neighborhood Development Corporation

Sarah Gleason
Reach Out and Read RI

Rabbi Leslie Y. Gutterman
Temple Beth El

Roberta Hazen Aaronson
Childhood Lead Action Project

Joanne P. Hoffman
Moses Brown School

Nondas Hurst Voll
Fund for Community Progress

Miriam Inocencio
Planned Parenthood of Rhode Island

Carole Jenny, MD
Hasbro Children's Hospital

Judy Jones
Rhode Island Housing

Sister Ann Keefe
St. Michael's Rectory

Heidi Keezer
Rhode Island Parents for Progress

Louise Kiessling, MD
Memorial Hospital

Christopher F. Koller
Neighborhood Health Plan of Rhode Island

Peg Langhammer
The Sexual Assault and Trauma Resource Center of RI

Dennis B. Langley
Urban League of Rhode Island

Joseph Le
Socioeconomic Development Center for Southeast Asians

Kristin Lehoullier
City Year Rhode Island

Victor Lerish, MD
Barrington Pediatric Associates

Lewis P. Lipsitt, Ph.D.
Brown University

Maureen Macera, Ph.D.
Woonsocket Education Department

Peter Marshall
East Providence Community Center

Patrick McGuigan
The Providence Plan

Eleanor M. McMahon, Ph.D.
A. Alfred Taubman Center for Public Policy

Sister Barbara McMichael
Providence Head Start, Inc.

Martha McVicker, Esq.
RI Disability Law Center

Fayneese Miller, Ph.D.
Brown University

James C. Miller
First Baptist Church in America

Clifford Montiero
NAACP, Providence Chapter

Luisa C. Murillo
Center for Hispanic Policy and Advocacy

Joseph Newsome
South Providence Development Corporation

Olga Noguera
RI Department of Human Services

Anne M. Nolan
Traveler's Aid Society of Rhode Island

Roger Nolan
Aquidneck Management Associates, Ltd.

Patricia Nolin
Options for Working Parents

Jane Nugent
United Way of Southeastern New England

Keith Oliveira
RI Urban Project

William Oh, MD
Rhode Island Hospital

Steven Ostiguy
Church Community Housing Corp.

Vidal Perez
Education Alliance at Brown University

Pauline Perkins-Moye
Newport Housing Authority

Howard Phengxophone
S.E. Asian Youth and Family Development Project

Karen Rakett
Junior League of Rhode Island

Brother Michael Reis
Tides Family Services

Marti Rosenberg
Ocean State Action Fund

Rosemary Santos
United Black & Brown Fund of RI

Monica Schaberg, MD
Bradley Hospital

Noreen Shawcross
RI Coalition for the Homeless

Henry Shelton
George Wiley Center

Peter Simon, MD, MPH
RI Department of Health

Geneva Singletary Johnson
N.E. Amer-I-Can

Richard Smith, MD
American Association of Pediatrics, RI Chapter

Allan W. Stein
Senior Vice President for Public Policy
United Way of Southeastern New England

Julia Steiny
Ed Watch
The Providence Journal

John Symynkywicz
DAWN for Children

The Honorable O. Rogeree Thompson
Rhode Island Superior Court

Judy Victor
Day Care Justice Co-op

Dawn Wardyga
Family Voices of Rhode Island

Reverend Marlowe V.N. Washington
Allen AME Church

Vivian Weisman
Rhode Island Parent Information Network

Elizabeth Wheeler, MD
Bradley Hospital

Sheldon Whitehouse
Attorney General

Thomas Whitten
John Hope Settlement House

Pheamo Witcher
The Genesis Center

Robert Wooler
RI Youth Guidance Center, Inc.

Acknowledgements

The 2002 Rhode Island KIDS COUNT Factbook was made possible by the efforts of many dedicated individuals. Rhode Island KIDS COUNT gratefully acknowledges their assistance.

William O'Hare, Don Crary, and Megan Reynolds of the Annie E. Casey Foundation for their encouragement and technical assistance.

Jack D. Combs, Research Administrator at the A. Alfred Taubman Center for Public Policy and American Institutions, Brown University, for data analyses. Samara Viner-Brown, Chief of the Office of Data and Evaluation at the Division of Family Health, for coordination and analyses of data from the RI Department of Health. Randy Rosati, Chief Human Services Policy & Systems Specialist, for coordination and analysis of data from the RI Department of Human Services. Terry Bergner, Senior Data Manager, for coordination and analysis of data from the RI Department of Education.

Wilsa Galarza, Rhode Island KIDS COUNT Administrative Assistant and Melanie Zamachaj for their assistance. Andrew Plyne and Joanna Ruocco, Rhode Island KIDS COUNT interns from Salve Regina University and Brown University. Greenwood Associates for the design and layout of the Factbook, Chil Mott and Gail Greenwood for the illustrations, and E.A. Johnson Co. for the printing of the Factbook.

Ron Gallo, Karen Voci, and Rick Schwartz of The Rhode Island Foundation for their ongoing support and assistance.

The State Agency Directors of the Rhode Island Children's Cabinet for their ongoing support of Rhode Island KIDS COUNT.

Members of the Rhode Island KIDS COUNT Factbook Advisory Committee and the State Agency Data Liaisons for their assistance in shaping the format and content of the Factbook. Members of the Rhode Island KIDS COUNT Board of Directors for their support. Thomas Anton, Brown University, Nancy Gewirtz, Rhode Island College, and William Hollinshead, MD, RI Department of Health for their review of the Factbook in draft form.

For their technical assistance with the following sections of the Factbook:

Child Population, Children in Single Parent Families, Racial and Ethnic Diversity, Racial and Ethnic Disparities: Nancy Gewirtz, Lenore Olsen, Rhode Island College; Thomas Anton, Jack Combs, Brown University; Samara Viner-Brown, Vania Brown-Small, RI Department of Health; Victor Capellan, Patricia Martinez, Providence School Department; Pablo Rodriguez, Women and Infants Hospital; Dennis Langley, Urban League.

Median Household Income: Jack Murphy, RI Department of Administration; Jean Burritt Robertson, Rhode Island Economic Development Corp.; Jack Combs, Brown University; Nancy Gewirtz, Rhode Island College.

Cost of Rent: Maura O'Brien, Judy Jones, RI Housing and Mortgage Finance Corp.; Eric Hirsch, Providence College and RI Food and Shelter Board; Noreen Shawcross, RI Coalition for the Homeless; Nancy Gewirtz, Rhode Island College; Barbara Fields-Karlin, RI LISC; Nancy Smith Greer, RI HUD Office; Jack Combs, Brown University.

Secure Parental Employment: Nancy Gewirtz, Rhode Island College; William O'Hare, Annie E. Casey Foundation; Matthew Jerzyk, RI Jobs with Justice.

Children Receiving Child Support: Jack Murphy, RI Department of Administration; Sherry Campanelli, RI Department of Human Services; Nancy Gewirtz, Rhode Island College.

Children in Poverty: Nancy Gewirtz, Lenore Olsen, Rhode Island College; Patricia Jaehnig, Diocese of Providence; Maura O'Brien, Rhode Island Housing and Mortgage Finance Corp.; Linda Katz, The Poverty Institute; William O'Hare, Annie E. Casey Foundation; Thomas Anton, Jack Combs, Brown University.

Children in the Family Independence Program: Sherry Campanelli, Donalda Carlson, Randy Rosati, Jeanette Cabral, RI Department of Human Services; Linda Katz, The Poverty Institute; Thomas Anton, Brown University; Nancy Gewirtz, Rhode Island College.

Children Receiving Food Stamps: Kathleen Gorman, University of Rhode Island Feinstein Center for a Hunger Free America; Sherry Campanelli, Randy Rosati, Robert McDonough, RI Department of Human Services; Bernard Beaudreau, RI Community Food Bank; Linda Katz, The Poverty Institute; Adrienne DiMeo, RI Department of Education.

Children Receiving School Breakfast: Kathleen Gorman, University of Rhode Island Feinstein Center for a Hunger Free America; Adrienne DiMeo, RI Department of Education; Bernard Beaudreau, RI Community Food Bank, Henry Shelton, Bill Flynn, George Wiley Center.

Children's Health Insurance: Diana Beaton, Sharon Kernan, John A.Y. Andrews, Sherry Campanelli, John Young, Joan Obara, Tricia Leddy, Frank Spinelli, Ron Ek, Olga Noguera, Lissa DiMauro, RI Department of Human Services; William White, Birch and Davis; Kertie Jones Clark, RI Health Center Association; Marti Rosenberg, Ocean State Action Fund; Linda Katz Poverty Institute; Deborah Silvia, RI Health Center Association; Brenda Seagrave-Whittle, NHPRI; Luisa Murillo, CHisPA; Stanley Block, MD, Providence Community Health Centers, Inc.; Samara Viner-Brown, William Hollinshead, Mia Patriarca, RI Department of Health; Karen Voci, The Rhode Island Foundation; William O'Hare, Annie E. Casey Foundation; Jack Combs, Brown University; Jane Griffin, MCH Evaluation, Inc.

Access to Dental Care: John A.Y. Andrews, Tricia Leddy, RI Department of Human Services, Maureen Ross, Robin Lawrence, DDS, RI Department of Health; Robert Persson, St. Joseph Hospital; Christine Vallee, St. Joseph Health Services of RI; Karen Voci, The Rhode Island Foundation; Hillary Salmons, Health and Education Leadership for Providence; Linda Katz, The Poverty Institute; Marty Mazzone.

Children's Mental Health: Elizabeth Earls, RI Council of Community Mental Health Centers; Eric Wood, Lifespan; Sandi Silva, John Peterson, Bradley Hospital; Jim Hallman, Susan Palmateer, Mary Brinson, Butler Hospital; Samara Viner-Brown, Rosemary Reilly-Chamat, RI Department of Health; Noelle Wood, RI Department of Mental Health, Retardation and Hospitals; Laureen D'Ambra, Office of the Child Advocate; Jane Hudson, Mental Health Advancement Resource Center.

Acknowledgements

Children with Special Needs: David Hamel, Peter Simon, MD, Christine Robin, Cynthia Holmes, RI Department of Health; Jennifer Wood, RI Department of Education, Dawn Wardyga, Family Voices; Michael Msall, MD, RI Hospital Child Development Center; Sharon Kernan, RI Department of Human Services; Martha McVicker, RI Disability Law Center.

Women and Children Receiving WIC: Becky Bessette, Charles White, John Smith, Samara Viner-Brown, Bethany Algiers, Bethany DiNapoli, RI Department of Health.

Breastfeeding: Becky Bessette, Charles White, Rachel Cain, Samara Viner-Brown, Bethany DiNapoli, RI Department of Health.

Women with Delayed Prenatal Care, Low Birthweight Infants, Infant Mortality: William Hollinshead, MD, Samara Viner-Brown, Vania Brown-Small, RI Department of Health; Suzanne Grossman, RI March of Dimes; Michael Msall, MD, RI Hospital Child Development Center; Myra Edens, Hasbro Children's Hospital; David Gagnon, National Perinatal Information Center; Jane Griffin, MCH Evaluation, Inc.

Children with Lead Poisoning: Al Cabral, Magaly Angeloni, Peter Simon, MD, Robert Vanderslice, William Hollinshead, MD, Anne Primeau-Faubert, Patrick MacRoy, RI Department of Health; Liana Cassar, Jeremy Giller, Jeff Brown, MD, June Tourangeau, HELP Lead Safe Center; Katie Murray, The Providence Plan; Hillary Salmons, Health and Education Leadership for Providence; Roberta Hazen Aaronson, Childhood Lead Action Project.

Children with Asthma: Michael Msall, MD, RI Hospital Child Development Center; Myra Edens, Hasbro Children's Hospital; Jay Buechner, Samara Viner-Brown, William Hollinshead, MD, Robert Vanderslice, RI Department of Health; David Gagnon, National Perinatal Information Center; Hillary Salmons, Health and Education Leadership for Providence.

Births to Teens: Samara Viner-Brown, Vania Brown-Small, RI Department of Health; Tricia Leddy, RI Department of Human Services; Jane Griffin, MCH Evaluation, Inc.;Suzanne Grossman, RI March of Dimes, Miriam Inocencio, Planned Parenthood of RI; Myra Edens, Patricia Flanagan, MD, Hasbro Children's Hospital; William O'Hare, Annie E. Casey Foundation.

Alcohol, Drug, and Cigarette Use by Teens: Cynthia Corbridge, RI Department of Education; Elizabeth Gilheeney, Governor's Justice Commission; Noreen Mattis, Project Link; Don Perry, Jan Shedd, Samara Viner-Brown, Jana Hesser, Jay Buechner, Sherri Knapp, Helen Drew, RI Department of Health.

Additional Children's Health Issues: Brenda Seagrave-Whittle, Ann Hochman, Neighborhood Health Plan of RI; Kim Salisbury-Keith, William Hollinshead, MD, Mimi Lazerele, Paula Lopes, Ana Novais, Don Perry, Rosemary Reilly-Chammat, Susan Shepardson, RI Department of Health; Karen Feldman, Youth In Action; David Gagnon, National Perinatal Information Center.

Child Deaths and Teen Deaths: Samara Viner-Brown, Nancy Libby-Fisher, Liz Arouth, Jay Buechner, RI Department of Health; David Pugatch, MD, Hasbro Children's Hospital; William O'Hare, Annie E. Casey Foundation.

Homeless Children and Homeless Youth: Anne Nolan, Travelers Aid; Eric Hirsch, Providence College and RI Emergency Food and Shelter Board; Judy Jones, RI Housing and Mortgage Finance Corp.; Noreen Shawcross, RI Coalition for the Homeless; Nancy Gewirtz, Rhode Island College; Virginia Bilotti, RI Department of Education; Rev. Robert Carter, Urban League; Frank Knapp, Nancy Heroux, StopOver Services of Newport; Brother Michael Reis, Tides Family Services; Laureen D'Ambra, Jan Dion Fontes, Office of the Child Advocate.

Juveniles Referred to Family Court: David Heden, Marguerite DiPalma, Richard Scarpellino, Ron Pirolli, Joe Baxter, RI Family Court; David Allenson, Mike Burk, RI Department of Children, Youth and Families; Elizabeth Gilheeney, Governor's Justice Commission; Laureen D'Ambra, Jan Dion Fontes, Office of the Child Advocate; Warren Hurlbut, Arlene Chorney, Roosevelt Benton, RI Training School; Attorney General Sheldon Whitehouse, Cindy Soccio, Susan Brazil, RI Office of the Attorney General; Brother Michael Reis, Tides Family Services; Robert Felner, National Center for Public Education and Social Policy.

Juveniles at the Training School: Arlene Chorney, Sara Little, RI Training School; Leon Saunders, David Allenson, Sue Bowler, Carol Whitman, RI Department of Children, Youth and Families; Brother Michael Reis, Robert Aichen, Tides Family Services; Mark Motte, Rhode Island College; David Heden, RI Family Court; Warren Hurlbut, Cindy Soccio, Susan Brazil, RI Office of the Attorney General; Laureen D'Ambra, Office of the Child Advocate; Elizabeth Gilheeny, RI Justice Commission.

Children of Incarcerated Parents: Teresa Foley, Judy Fox, Evelyn Henley, Jen Olivelli, Roberta Richman, RI Department of Corrections; Dianne Sprague, Women in Transition.

Children Witnessing Domestic Violence: Deborah Debare, Patricia Loomis, Mao Yang, RI Coalition Against Domestic Violence; Janice Dubois, Nancy King, RI Supreme Court Domestic Violence Training and Monitoring Unit; Eric Hirsch, Providence College and the RI Emergency Food and Shelter Board.

Child Abuse and Neglect: Leon Saunders, Tom Dwyer, David Allenson, Department of Children, Youth and Families; Laureen D'Ambra, Jan Dion Fontes, Office of the Child Advocate; Deborah DeBare, Francie Mantak, RI Coalition Against Domestic Violence; Lenette Azzi-Lessing, Children's Friend and Service; Lenore Olsen, Rhode Island College; Peg Langhammer, Sexual Assault & Trauma Resource Center of RI; Samara Viner-Brown, RI Department of Health; Bernard Smith, St. Mary's Home for Children.

Children in Out-of-Home Placement: Leon Saunders, David Allenson, RI Department of Children, Youth and Families; David Heden, Joseph Baxter, David Tassoni, RI Family Court; Jan Dion Fontes, Laureen D'Ambra, Office of the Child Advocate; Bernard Smith, St. Mary's Home for Children; Cathy Lewis, Casey Family Services; Darlene Allen, Adoption RI; Elizabeth Fuerte, New Visions Project Head Start; Randi Braunstein, RI Family Works; Lenore Olsen, Rhode Island College; Kate Begin, Prevent Child Abuse RI; Charlene Zienowicz, Urban League.

Acknowledgements

Infant and Pre-School Child Care, School-Age Child Care, Children Receiving Child Care Subsidies: Patricia Nolin, Options for Working Parents; Leanne Barrett, United Way of Southeastern New England; Reeva Sullivan Murphy, Larry Pucciarelli, Sherry Campanelli, Randy Rosati, Carol Ponto, RI Department of Human Services; Barbara Burgess, George McDonough, RI Department of Education; Alexandra Moser, Office of Child Care, Diocese of Providence; Mary Ann Shallcross, Mary Beth Young, Child Care Connection; Nancy Benoit; Nancy Gewirtz, Rhode Island College; Barbara Cavallaro, RI Child Care Director's Association; Joyce Butler, Maryann Finamore-Allmark, RI Public Policy Coalition for Child Care; Lenette Azzi-Lessing, Teri DeBoise, Children's Friend and Service; Lynda Dickinson, CHILD, Inc.; Patricia Martinez, Providence School Department; Thomas Anton, Eleanor McMahon, Jack Combs, Brown University; Julia Steiny; Robert Felner, Lynda Hurditch, National Center for Public Education and Social Policy; Marybeth Young, Child Care Connection.

Children Enrolled in Head Start: Reeva Sullivan Murphy, Larry Pucciarelli, Sherry Campanelli, RI Department of Human Services; Roy Walker, U.S.H.H.S, Administration for Children and Families; Toni Enright, Cranston Child Development Center; Lynda Dickinson, CHILD, Inc.; Carol Cooper, Providence Head Start, Inc.; Carol Hemingway, South County Community Action; Mary Nugent, East Bay Head Start; Cindy Larson, RI-LISC; Susan Connaughton, Tri-Town Community Action Agency; Karen Bouchard, Woonsocket Head Start and Day Care; Lenette Azzi-Lessing, Teri DeBoise, Children's Friend and Service; Eleanor McMahon, Brown University; Karen Pucciarelli, New England Resource Center.

Full Day Kindergarten: Virginia da Mota, Barbara Burgess, Terry Bergner, Charlotte Diffendale, Rick Richards, RI Department of Education.

English Language Learners: Maria Lindia, Terry Bergner, RI Department of Education; Victor Capellan, Providence School Department; Melba Depeña; Gladys Gould, Direct Action for Rights and Equality.

Children Enrolled in Special Education: Jennifer Wood, RI Department of Education; Martha McVicker, RI Disability Law Center; Dennis Cheek, Terry Bergner, Charlene Gilman, Thomas DiPaola, Barbara Burgess, Karen Cooper, Joseph Pangborn, RI Department of Education; Michael Msall, MD, RI Hospital Child Development Center; William Hollinshead, MD, Samara Viner-Brown, Rachel Cain, Chris Robin, Peter Simon, MD, David Hamel, RI Department of Health; John A.Y. Andrews, RI Department of Human Services; Dawn Wardyga, Family Voices; Jane Griffin, MCH Evaluation, Inc.

Student Mobility: Katie Murray, Jim Vandermillen, The Providence Plan; Julia Steiny; Maura O'Brien, RI Housing and Mortgage Finance Corp.; Robert Oberg, The Children's Crusade; Nicole Hebert, Children's Friend and Service; Terese Curtin, Connecting for Children and Families, Inc.; Christine Arouth, Newport School Department; Samara Viner-Brown, RI Department of Health; Susanna Greschner, RI Public Expenditure Council.

Fourth-Grade Reading Skills: Terry Bergner, Dennis Cheek, James Karon, Diane DiSanto, Karen Cooper, Virginia da Mota, Cynthia Corbridge, Pat DeVito, Paula Rossi, Jane Correia, Mary Ellen Sacco, RI Department of Education; Karen Voci, The Rhode Island Foundation; Julia Steiny, Robert Felner, National Center for Public Education and Social Policy.

High-Performing Schools: Dennis Cheek, RI Department of Education.

School Attendance: Terry Bergner, RI Department of Education; John Wirt, Tom Snyder U.S. Department of Education; Patrick McGuigan, The Providence Plan; Michael Jolin, Johnston School District; Judge Joan Byer, Linda Wilhelms, Truancy Diversion Project of Jefferson County, Kentucky; Sargent Richard Rodriguez, New Haven Department of Police Services.

Suspensions: Terry Bergner,Virginia da Mota, George McDonough, RI Department of Education; Representative Aisha Abdullah-Odiase, RI General Assembly; Thomas Mezzanotte, Providence School Department.

High School Graduation Rate: Cynthia Garcia Coll, Brown University; Sandra Enos, Rhode Island College; Victor Capellan, Providence School Department; Jane Nugent, United Way of Southeastern New England; Robert Wooler, RI Youth Guidance Center; Lenette Azzi-Lessing, Children's Friend and Service; Dennis Cheek, Terry Bergner, George McDonough, Karen Cooper, Virginia da Mota, Cynthia Corbridge, Pat DeVito, Paula Rossi, Jane Correia, Mary Ellen Sacco, RI Department of Education; Karen Voci, The Rhode Island Foundation.

Teens Not in School and Not Working: Ron Pagliarini, RI Family Court; Linda Soderberg, RI Department of Labor and Training; Jack Combs, Brown University.

Poetry Credits

"He Wishes for the Cloths of Heaven" by William Butler Yeats, reprinted from *Favorite Poems Old and New* (1957). Garden City, NJ: Doubleday & Co., Inc.

"I, Too" by Langston Hughes, reprinted from *The New Oxford Book of Children's Verse* (1996). New York, NY: Oxford University Press.

"Ode to My Shoes" by Francisco X. Alarcon, reprinted from *The Bellybutton of the Moon and Other Summer Poems* (1998). San Francisco, CA: Children's Book Press.

"The Red Kite" by Lilian Moore, reprinted from *Treasury of Children's Poetry* (1998). London: Hutchinson Children's Books.

"In Beauty May I Walk", Navajo, reprinted from *The New Oxford Treasury of Children's Poems* (1995). New York, NY: Oxford University Press.

"Where Go the Boats?" by Robert Louis Stevenson, reprinted from *The New Oxford Book of Children's Verse* (1996) New York, NY: Oxford University Press.

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

[X] This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

[ ] This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").